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No. 84-

IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1984

THE COMMONWEALTH OF MASSACHUSETTS
by its DEPARTMENT OF PUBLIC WELFARE,
Petitioner,

v.

SECRETARY OF THE UNITED STATES
DEPARTMENT OF HEALTH AND
HUMAN SERVICES,

ADMINISTRATOR OF THE HEALTH CARE
FINANCING ADMINISTRATION,

and

THE DEPARTMENTAL GRANT APPEALS BOARD,
Respondents.

PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

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Issues Presented

1. Where the Commonwealth properly purchases nursing home care for the needy at interim rates in accordance with a Medicaid plan approved by the Secretary, is the Secretary authorized by the terms of the federal-state partnership agreement to refuse to reimburse the Commonwealth for the federal share of its unrecoverable expenditures in excess of the allowable costs of the nursing homes as later determined in final rates set in accordance with the plan?

2. Where the Court of Appeals found that the cornerstone provision of Title XIX, establishing the Commonwealth's right to reimbursement, is equivocal, did it err in deferring to the Secretary's contention, not embodied in

regulations, that Congress intended to permit her to determine retroactively and unilaterally not to pay the federal share of Medicaid funds properly expended by the Commonwealth in full compliance with its approved plan to purchase nursing home care for the needy?

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THE COMMONWEALTH OF MASSACHUSETTS
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SECRETARY OF THE UNITED STATES
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and

DEPARTMENTAL GRANT APPEALS BOARD,
Respondents.

PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

The Commonwealth of Massachusetts hereby petitions this Court for a writ of certiorari to review a judgment of the United States Court of Appeals for the First Circuit.

Opinions Below

The opinion of the District Court is reported at 576 F. Supp. 1565 (1984), and is printed in the Appendix to the Petition (Pet. App.) at 41-56. The opinion of the Court of Appeals is reported at 749 F.2d 89 (1984), and is printed in the Appendix at 1-38. The Departmental Grant Appeals Board issued three opinions, of which the second, issued February 26, 1982, forms the subject matter of this petition. That opinion is printed in the Appendix at 57-122.

Jurisdiction

The judgment of the Court of Appeals for the First Circuit was entered on November 28, 1984. Pet. App. at 123. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

Statutes Involved

The statutory provisions involved are sections 1903 and 1905 of the Social Security Act, 42 U.S.C. §§ 1396b, 1396d. Pertinent portions of these statutes are reproduced in the Appendix to this Petition. Pet. App. at 124 et seq.

Statement of the Case

1. Title XIX of the Social Security Act (Medicaid), 42 U.S.C. §§ 1396 et seq., makes federal funds available to enable each participating state to furnish medical assistance, rehabilitation, and other services to needy persons. 42 U.S.C. § 1396. A state wishing to join in partnership with the United States for this purpose must submit a plan conforming to the specifications of 42 U.S.C. § 1396a (and the Secretary's elaboration of § 1396a in her regula-

tions) for the Secretary's approval.

Section 1396b(a) states the basic terms of the "contract", and § 1396b (a)(1) states the basic terms upon which the largest share of federal disbursements, those for medical assistance expenditures, are made. Under that section, once the state plan has been approved, the state is entitled to receive partial federal reimbursement for its expenditures under the plan.[1/]

1/ Section 1396b(a)(1) provides in part:

> (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this subchapter, for each quarter ...
>
> (1) an amount equal to the Federal medical assistance percentage ... of the total amount expended during such quarter as medical assistance under the State plan ....

While the list of statutory qualifications of this obligation has grown, the

(footnote continued)

Although participating states are allowed some discretion in choosing the types of services to be covered under their programs, they are required to cover certain types of services, including skilled nursing facility services. See 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4) (1983). Massachusetts has chosen to cover intermediate care facility services as well. See 42 U.S.C. § 1396d(a)(15) (1983). For purposes of this petition, the Commonwealth will refer to both categories as nursing home services.

2. Under Title XIX of the Social Security Act, as it existed before 1980,[2/] three cardinal but potentially

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(footnote continued)

Secretary has not relied on any such qualification in these proceedings.

2/ Unless otherwise indicated, the Commonwealth will describe the Act as it existed before 1980, the relevant period for purposes of this petition.

conflicting principles governed nursing home reimbursement. First, the states were obliged to reimburse nursing homes "on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary." 42 U.S.C. § 1396a(a)(13)(E) (1979).[3/] The Secretary by regulation construed this provision to require that rates be sufficient "to reimburse in full the actual allowable costs of a facility that is economically and effi-

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3/ This provision was entirely rewritten in 1980, and was further amended and renumbered as § 1396a(a)(13)(A) in 1981. Pub. L. No. 96-499, § 962 (1980); Pub. L. No. 97-35, § 2173(a)(1) (1981). As rewritten, the provision affords the states additional leeway to devise reimbursement systems. The added discretion, however, does not diminish and may increase the states' jeopardy of a disallowance, if the Secretary's position in this case is sustained.

ciently operated." 42 C.F.R. § 447.302(b) (1979).

Second, while § 1396a(a)(13)(E) was understood to require full reimbursement of actual allowable costs, 42 U.S.C. § 1396b(i) (1979) provided that there would be no federal reimbursement for state expenditures exceeding the amount which would be paid for such care and services under the Medicare program, Title XVIII of the Social Security Act. See 42 C.F.R. §§ 447.252, .315, .316 (1979) (federal financial participation is available for expenditures which do not exceed the provider's customary charge or rates which would be paid using Medicare principles of reimbursement).

Third, to ensure the participation of providers, Title XIX requires prompt payment of invoices for care and services. See Massachusetts General Hospi-

tal v Sargent, 397 F. Supp. 1056, 1061-62 (D. Mass. 1975).[4/] See also 42 U.S.C. § 1396a(a)(37), as amended by Pub. L. No. 95-142, §§ 2(b)(1)(C), 3(c)(1)(C), 7(b)(1); 42 C.F.R. § 447.45(1979) (requiring payment of 90 percent of invoices submitted by individual providers or group practices within thirty days, and 99 percent within ninety days).

The Secretary has attempted to achieve these competing objectives for prompt, full, and accurate reimbursement by requiring payment at rates based on reported costs, subject to adjustment after an audit. See 42 C.F.R. § 447.302(b)(1979). This can be accom-

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4/ The court relied in part on the Secretary's Medicare regulations, which required "[i]nterim payments approximating the actual costs of the provider" to be made "not less often than monthly." 397 F. Supp. at 1061, quoting 20 C.F.R. § 405.454(a).

plished in one of two ways. Under a prospective reimbursement system, the rate for any year is derived from costs reported by the nursing home in an earlier year (the base year). No adjustment of the rate is subsequently made to reflect actual costs during the rate year, but the state conducts an on-site audit of the home to determine whether the home properly reported its costs during the base year and whether any nonallowable costs were included. A prospective rate may be adjusted retroactively based on the results of this audit.

Massachusetts and other states have opted to employ a retrospective ratesetting system,[5/] under which final per

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5/ The Commonwealth is informed that ten other states employ retrospective rate systems for one or more classes of providers. They are Florida, Idaho, Mis-

(footnote continued)

diem rates are established after the rate year based on the nursing homes' reports of their costs for the year. Such a system is a recognized option under the Secretary's regulations. See 42 C.F.R. § 447.272 (1979). However, because the final rate is not determined until well after the close of the rate year, the Secretary's regulations require Massachusetts to establish interim or estimated rates at the start of the year. In Massachusetts the interim rate is determined by adjusting the final rate for an earlier year to reflect inflation.6/

(footnote continued)

souri, New Hampshire, New Mexico, New York, Ohio, Oregon, Pennsylvania, and Wisconsin. In addition, Alabama, Nevada, and Virginia employ hybrid systems which are retrospective in part.

6/ Thus, the interim rate under Massachusetts's retrospective system corresponds to the final rate in a prospective system.

Because the interim and final rates are derived by different means from different base data, it is an inherent feature of a retrospective system that the interim rate will differ from the final rate.[7] If the final rate is higher than the interim rate, the Commonwealth must pay an additional amount to the nursing home equal to the rate differential times the total Medicaid patient days for the year. If the final rate is lower than the interim rate, the nursing home must repay the Commonwealth. The Commonwealth will refer to these latter claims as "rate decrease claims."[8]

7/ For instance, if the actual rate of inflation is lower than expected, the final rate will be lower because actual costs will be lower than predicted in the interim rate.

8/ The Commonwealth expends in excess of $400 million per year for nursing

(footnote continued)

In the usual case, the Commonwealth collects rate decrease claims either by deducting a percentage from current monthly payments to the nursing home, or by offsetting the claim against any lump sum payments which may be owing to the nursing home.9/ Because recovery of these claims and repayment of the federal share occurs promptly, this system ordinarily presents no problem. Occasionally, however, nursing homes go out of business or declare bankruptcy before a rate de-

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(footnote continued)

home services under the Medicaid program. If final rates deviated on average 5% from interim rates, and if one half of final rates were lower than the interim rates, the Commonwealth's system would generate $10 million in rate decrease claims per year. In fact, we are informed that, in 1980 and 1981, rate decrease claims were generated at the rate of about $12 million per year.

9/ Rate decrease claims are almost always collected from operating homes within one year. See Pet. App. 81.

crease claim has been established,[10/] or before it has been collected. For the most part such claims are uncollectible, in the case of bankrupt homes because they have been discharged by operation of federal law. In such cases, the question arises whether the Secretary may demand repayment of the federal share, thereby forcing the Commonwealth to bear the entire loss.

3. In 1979, agents of the Secretary audited the Commonwealth's financial records and determined that, as of September 30, 1979, the Commonwealth had outstanding rate decrease claims against bankrupt or out of business nursing homes

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10/ Plainly, because cost reports are filed after the close of the year, the final rate for the last year of a nursing home's operations could not be set before it ceases business or declares bankruptcy.

in the amount of $10,231,222.[11/] The federal share of these claims was said to be in excess of $5 million. Pet. App. at 64-65.

The Secretary's auditors did not find that the interim rates, upon which these payments had been made, were improperly calculated, or that any invoices were improvidently paid. On the contrary, the Secretary has assumed from the start that the interim rates were properly calculated, and has conceded for purposes of this case that all payments were made in accordance with the Commonwealth's plan, which the Secretary has approved. Nor has the Secretary alleged that these

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11/ This figure represented the accumulated total of unpaid claims from the inception of the retrospective system to the date of the audit. About $5.5 million consisted of claims against bankrupt nursing homes.

claims resulted from improper or inefficient administration; rather, they unavoidably arose as a byproduct of the Commonwealth's approved retrospective reimbursement system. Nor, finally, has the Secretary claimed that the interim rates at which the Commonwealth paid these nursing homes exceeded the upper limits established by Title XIX and the Secretary's regulations. See 42 U.S.C. §§ 1396a(a)(30), 1396b(i) (1979); 42 C.F.R. §§ 447.252, .315, .316 (1979).

Despite the fact that the Commonwealth had originally disbursed these sums properly, in accordance with its approved plan, and despite the absence of any regulation defining rate decrease claims as expenditures not entitled to

federal reimbursement,[12/] the Secretary's auditors alleged that the outstanding rate decrease claims in fact represented improper expenditures. Reasoning that these claims were determined by the Commonwealth to be overpayments to the nursing homes, the Secretary concluded that they were not "medical assistance" expenditures for which the Commonwealth was entitled to receive federal reimbursement. See 42 U.S.C. §§ 1396b (a)(1), 1396d(a). Accordingly, the Sec-

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12/ On April 5, 1983, the Secretary published proposed regulations which would spell out in some detail the states' obligations to identify and report overpayments to providers. 48 Fed. Reg. 14664 (April 5, 1983). Among other things, the regulations would define "overpayment" as "the amount, paid to a provider by a Medicaid agency, that HCFA determines to be in excess of the amount to which the provider was entitled," and would provide for recovery of the federal share of such overpayments whether or not the state recovers from the provider. Id. at 14667. The proposed regulations have not been promulgated.

retary demanded that the Commonwealth deduct the federal share of those claims immediately from the Commonwealth's next quarterly report of estimated expenditures, upon which federal reimbursement is based. See 42 U.S.C. § 1396b(d)(1).

On reconsideration of the Secretary's position, see 42 U.S.C. § 1316(d), the Grant Appeals Board (the Board), giving great weight to the Secretary's views, ruled that, to the extent an interim rate exceeds a final rate, payments at the interim rate are improper, and therefore do not qualify as expenditures for "medical assistance under the State plan," within the meaning of 42 U.S.C. § 1396b (a)(1). Federal payments to the Commonwealth based on such "improper" expenditures were, thus, overpayments which the Secretary was authorized by 42 U.S.C. § 1396b(d)(2) to deduct from subsequent

payments. Pet. App. at 67-73. On February 26, 1982, the Board issued its decision upholding the Secretary's authority in the circumstances, but leaving the amount of the disallowance to be resolved after further proceedings. Pet. App. at 121-22. That amount was ultimately fixed by the Board on June 30, 1983, at almost $4 million.

4. On April 22, 1982, the Commonwealth simultaneously filed a petition for review, pursuant to 42 U.S.C. § 1316(a)(3), in the United States Court of Appeals for the First Circuit, and this action in the District Court under 5 U.S.C. §§ 702, 703, and 28 U.S.C. § 2201, for judicial review of the Board's decision and for declaratory and injunctive relief against the Secretary. The jurisdiction of the District Court was founded upon 28 U.S.C. § 1331. This

action was stayed, on the Commonwealth's motion, pending decision of the petition in the Court of Appeals.

In January, 1983, the Court of Appeals determined that it did not have jurisdiction of the petition. Commonwealth of Massachusetts v. Departmental Grant Appeals Board, 698 F.2d 22 (1st Cir. 1983).[13/]

Following that decision, the parties filed cross-motions for summary judgment in the District Court. On January 12, 1984, that court (Garrity, J.) issued

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13/ The Court of Appeals stayed entry of its decree until the judgment of the District Court could be reviewed on appeal. The reason for the stay was a doubt as to whether the District Court had jurisdiction. The District Court found that it had jurisdiction. Pet. App. 47. Because the merits of the complaint were reached and decided by the courts below, the Commonwealth does not seek review of the decree of the Court of Appeals on the petition under 42 U.S.C. § 1316(a)(3).

its decision, and a judgment was entered the next day. Pet. App. 39-40.

The District Court disagreed with the Board's approach to the question, and reversed its decision. Given the Secretary's concession that the expenditures in issue had been made in accordance with the Commonwealth's approved plan, and the absence of any clear statutory or regulatory authorization to treat such expenditures as improper once a final rate had been determined, the District Court gave controlling weight to the overall character of the Medicaid program as a federal-state partnership. Pet. App. at 54, quoting Harris v. McRae, 448 U.S. 297, 308-09 (1981). Accordingly, the District Court held that the Commonwealth was not required to repay the federal share of its rate decrease claims except to the extent that those claims

were recovered from the nursing homes. Pet. App. at 54-55, citing 42 U.S.C. § 1396b(d)(3).

5. The Secretary appealed the judgment of the District Court and, on November 28, 1984, the Court of Appeals reversed. While it found that the terms of the statute could support either position, the Court of Appeals rejected the District Court's reliance upon the character of the Medicaid program as a partnership, since the court thought it equally consistent with such a relationship for the federal government to cast the entire burden of uncollectible claims on the Commonwealth. Pet. App. at 35-37.

The Court of Appeals also rejected the Commonwealth's argument that the Secretary's position was not clearly stated in the statute or in her regulations, and so was invalid. In the Court's view,

the "clear statement" rule articulated in Pennhurst State School & Hospital v. Halderman, 451 U.S. 1, 17 (1978),[14] is applicable to the determination of the existence vel non of conditions under a grant program, but not to the determination of the scope or application of a particular condition the existence of which is not in doubt. Pet. App. at 28-30. As to the latter issue, the Court of Appeals ruled that the Secretary's construction of the statutes was entitled to deference. Because the terms of the

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14/ We use the phrase "clear statement rule" as shorthand for the following passage in the Pennhurst decision:

> [I]f Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously. ... By insisting that Congress speak with a clear voice, we enable the States to exercise their choice knowingly, cognizant of the consequences of their participation.

451 U.S. at 17.

statute did not clearly support either position, the Secretary's construction of the statute was deemed determinative. Pet. App. at 32-35.

Reasons Why the Writ Should Be Allowed

I. THE DECISION BELOW MERITS REVIEW BECAUSE IT FUNDAMENTALLY DISTORTS THE RELATIONSHIP BETWEEN THE STATES AND THE UNITED STATES UNDER TITLE XIX.

The decision below puts questions of tremendous importance to the federal-state partnership authorized by Title XIX. Whether the Secretary must pay the federal share of expenditures required by an approved plan, or whether she may, on the contrary, refuse payment based on facts which were not reasonably knowable when the expenditures were made, is sufficiently important in itself to merit review and resolution by this Court, as

the Commonwealth will show in its next point.

But the Secretary's position strikes more deeply than the mere question of the Commonwealth's just expectation of reimbursement. While the Secretary has always exercised pervasive control over the formulation of state plans, through her power to interpret and fill out the provisions of § 1396a, and her power to approve or disapprove proposed plans and plan amendments, and while Congress has with increasing frequency provided incentives (or disincentives) to encourage accurate and efficient administration of state programs, it has always been thought that Title XIX authorizes partnerships, in which the states have discretion within known limits to adopt such systems as seem wise and appropriate for the achievement of the mutual goal of

furnishing medical assistance to the needy.

The Secretary's assertion of a general authority to refuse federal reimbursement for expenditures which she deems in hindsight to have been uneconomical or unnecessary, though they may be authorized or even required by the state's approved plan, belies any conception of Title XIX programs as a partnership. Not only does it repudiate any obligation to share the risks of the enterprise, but it also denies any obligation to identify in advance those risks which the federal government will not share, so that the states may avoid or minimize them.

The consequence is that, though the states may have discretion under federal law to design their programs as they see fit, neither the faultless operation of

the program, nor the Secretary's approval of its design will ensure that the federal government will share the program's cost. This is not discretion in the ordinary sense, for the asserted power denies all reliance or trust by the federal government in the states' management of their programs, even within the bounds of plans reviewed and approved in advance by the Secretary.

This was not Congress's intent in enacting Title XIX, as described by this Court, inter alia, in Harris v. McRae, 448 U.S. at 308-09.

Related to this question is the proper judicial approach to the resolution of disputes involving the basic rights and obligations of the states and federal government.

Both the District Court and the Court of Appeals concluded that the statute

itself is ambiguous on the issue presented in this case. The District Court resolved the dispute by giving determinative weight to the nature of Title XIX as a partnership. Pet. App. at 51, 53-54. The Court of Appeals, on the other hand, resolved the dispute by deferring to the Secretary's position. Pet. App. at 32-35.

The Commonwealth will argue in its third point that the question whether the Court of Appeals erred in adopting a stance of deference is one which this Court should review and decide. The Commonwealth observes here, however, that like the court's decision of the substantive issue, its approach to the interpretation of the statute seriously skews the relationship of the states to the federal government. To defer to the Secretary's post hoc definition of the fed-

eral obligation, and especially to defer to that interpretation on the ground that it is merely rational, that it can be said to further some end within the constellation of permissible governmental ends, is to transform a relationship which this Court has characterized as contractual in nature into a relationship between a regulator and regulatee.15/

In Bell v. New Jersey, 461 U.S. 773 (1983), Justice White identified these issues as matter for concern, id. at 794

15/ Of particular significance to the Court of Appeals was the additional fiscal protection that the Secretary's approach allegedly affords to the federal government, and the additional incentive it gives the states to operate their programs efficiently. Pet. App. at 35-37. The court's reliance on these objectives, and its lack of concern for whether the means chosen to achieve them were agreed to by the states, suggests that it viewed the issue as one concerning the rationality of an exercise of regulatory authority. The Secretary, too, has defended her position as if it were such an exercise.

(White, J., concurring), but the Court has not heard a case concerning the scope of the Secretary's disallowance authority before the current term. Three cases now pending before the Court present that issue in varying lights. See Kentucky Department of Education v. Secretary of Education, 717 F.2d 943 (6th Cir. 1983), cert. granted, 105 S. Ct. 78 (1984); State of New Jersey v. Hufstedler, 724 F.2d 34 (3rd Cir. 1983), cert. granted, 105 S. Ct. 79 (1984); State of Connecticut v. Heckler, 731 F.2d 1052 (2d Cir.), cert. granted, 105 S. Ct. 321 (1984). The Commonwealth suggests that the instant case may aid in clarifying the nature of the federal promise in spending power programs, and in the determination of the proper stance of a court reviewing a disallowance which is based upon a

nonobvious interpretation of a governing statute.

II. THE COURT'S HOLDING THAT STATES ARE NOT ENTITLED TO REIMBURSEMENT FOR EXPENSES PROPERLY INCURRED UNDER THEIR APPROVED PLANS IS AN IMPORTANT FEDERAL QUESTION WHICH SHOULD BE REVIEWED BY THIS COURT.

Congress enacted Title XIX in 1965 to encourage and assist the states to provide medical care to needy persons. See 42 U.S.C. § 1396. It chose to carry out this policy by proposing a partnership with each state, in which, in return for an agreement by the state to administer a program in conformity with federal specifications, the federal government would reimburse a portion of state expenditures under the program.

In Harris v. McRae, 448 U.S. 297, 308-09 (1981), this Court said that "the purpose of Congress in enacting Title

XIX was to provide federal financial assistance for all legitimate state expenditures under an approved Medicaid plan." The decision below challenges that view. On the record in this case, the Commonwealth did what was required of it by its approved plan and the Secretary's regulations. The Commonwealth's expenditures, judged as of the time they were made, were necessary and proper. Nevertheless, the Secretary has determined that she need not pay the full federal share of these expenditures, based on facts and circumstances which were not and could not have been known when the expenditures were incurred. The issue thus drawn is of profound importance to the administration of Title XIX.

Of course the decision of the Court of Appeals is of moment to the Commonwealth because of the sum involved, al-

most $4 million. But of greater moment is the decision's implication for the future. Because rate decrease claims are an inevitable feature of retrospective rate systems, the decision of the Court of Appeals ensures continuing losses of federal financial participation for so long as the Commonwealth employs such a system. Nor is this the concern of the Commonwealth alone. Retrospective rate systems are employed by ten other states,[16/] and the Secretary has already disallowed reimbursement to at least four of those states in reliance upon her reasoning in this case.[17/]

16/ The states are listed in footnote 5, supra.

17/ See Florida Department of Health & Human Services, Board Decision No. 296 (May 14, 1982) aff'd sub nom. State of Florida v. Heckler, Civil Action No. TCA

(footnote continued)

Furthermore, the decision below, while perhaps in keeping with the federal government's short-term financial interest, is not in harmony with the policies of Title XIX. First, since the decision below relieves the Secretary of any obligation to share even in inherent, foreseeable expenses under a state plan to the extent that they exceed the ideal

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(footnote continued)

82-0935 (N.D. Fla., January 5, 1984); Missouri Department of Social Services, Board Decision No. ___, rev'd sub nom. Department of Social Services v. Heckler, Civil Action No. 84-4106-CV-C-5 (W.D. Mo., September 10, 1984); New York State Department of Social Services, Board Decision No. 284 (April 29, 1982), aff'd, Perales v. Heckler, Civil Action No. 83-CV-900 (N.D.N.Y., October 1, 1984); Pennsylvania Department of Public Welfare, Board Decision No. 426 (May 24, 1983). About four months before its decision in the instant case, the Board upheld a similar disallowance in Ohio Department of Public Welfare, Board Decision No. 226 (October 30, 1981). The Board did not rely on that decision in this case.

level of expenditures, its effect is to decrease the federal government's share in the overall cost of furnishing medical assistance and to increase the state's cost. Given that available state funds are not inexhaustible, and that the state has the power to limit its expenditures by altering the design of its program, an increase in the state's share of the cost of furnishing services may provoke an offsetting decrease in the scope of the state's program, or of the services offered. Because federal funds are made available on a matching basis, the savings which the decision below may achieve in federal expenditures may well translate into fewer services for the needy. In this way, the Secretary's position that the states must bear alone some costs which cannot be avoided works against Congress's purpose to enable the

states "as far as practicable under the conditions in each State" to furnish medical assistance to the needy. 42 U.S.C. § 1396.

Second, while the Secretary and the Court of Appeals pay lip service to the states' role in the Medicaid program, and while both purport to recognize the freedom reserved to the states to fashion programs within the federal statutory framework, the decision in effect attaches a penalty (or negative incentive, as the Court of Appeals would have it, see Pet. App. at 36-37) to a program choice which otherwise complies with federal law. Congress has provided that the Commonwealth is entitled to receive partial federal reimbursement for its expenditures under its plan except as otherwise provided in § 1396b. A variety of provisions in § 1396b qualify that

premise. So, for instance, until 1981, § 1396b(i) provided that states would not be entitled to reimbursement for expenditures to the extent that they were made at rates exceeding what would be paid under Medicare. See also § 1396b (b), (f)-(m), (o), (r), (s), (u). But these explicit qualifications still leave room for the states to exercise their own judgment in fashioning programs to achieve the objectives of the Medicaid act. The decision below, however, permits the Secretary retroactively to impose financial constraints without explicit authority in § 1396b. In so doing, the decision authorizes the Secretary to control the states' exercise of the discretion left to them by Congress.

Third, although the Court of Appeals thought it reasonable to cast the entire risk of loss in a retrospective system

upon the Commonwealth,[18] this choice is likely to disserve congressional policy in the long run. For, the decision below could encourage inefficiency or noncompliance with the State plan. If rate decrease claims can only come into being when final rates are set, the decision below could encourage the states not to set such rates or to set them automatically at the same level as the interim rates for nursing homes which are not financially sound, or have already declared bankruptcy.[19] More

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18/ The court below recognized that the Commonwealth would be an equal partner in any loss, even if the court ruled in its favor, but thought that casting the entire loss on the Commonwealth would increase its incentive to operate its program efficiently. Pet. App. at 36-37.

19/ This is so because under the Secretary's scheme if a state recovers less than fifty percent of its claim in the bankruptcy court, it will be worse

(footnote continued)

broadly, because the risk of loss is greatest when the state exercises the strictest scrutiny of nursing home costs, the decision below discourages state initiatives to control such costs.

In its general aspect, the issue in this case is whether the Secretary may judge the legitimacy of state expenditures based on facts and circumstances which could not reasonably have been known when the expenditures were made. The question profoundly affects the "partnership" between the federal government and the states. If the Secretary is correct, then the relationship is one in which all risks, even inherent or un-

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(footnote continued)

off than if it had simply avoided the creation of a claim by setting the final rate at the same level as the interim rate.

avoidable risks, are borne by the states, and in which the Secretary, under the guise of her disallowance power, may second guess every aspect of a state's administration of its program.20/

So far as we are aware, this Court has not, prior to the current term, addressed the scope of the Secretary's power to define the federal reimbursement obligation and to disallow reimbursement for state expenditures in a cooperative

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20/ The Secretary has proposed regulations under which the legitimacy of state expenditures would depend on the Secretary's independent after-the-fact determination of rates for providers, even though the state may be required by state law or court decision to pay at a different rate. See 48 Fed. Reg. 14664 (April 5, 1983), discussed in footnote 12, supra. Indeed, the Secretary has asserted such authority in at least one disallowance. See South Carolina Department of Social Services, Board Decision No. 149 (February 3, 1981).

grant program.[21] The question has been considered by the lower courts,[22] and will recur with increasing frequency if it is not addressed and resolved by

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21/ The Court has frequently heard cases concerning the states' obligations under such programs. In Bell v. New Jersey, 461 U.S. 773 (1983), the Court considered the federal government's remedial options when a state misspends federal grant money. Justice White identified the scope of the disallowance power as an issue of concern, see id. at 794 (White, J., concurring), but the question has not been squarely presented before this term.

22/ See, e.g., California v. Settle, 708 F.2d 1380 (9th Cir. 1983) (Secretary need not reimburse erroneous payments under Title XIX even though they are practically unavoidable); County of Alameda v. Weinberger, 520 F.2d 344 (9th Cir. 1975) (Secretary may not disallow Title VI expenditures which are authorized by an approved plan, even though they allegedly violated the Secretary's regulations); Solomon v. Califano, 464 F. Supp. 1203 (D. Md. 1979) (Secretary may not disallow Title XIX expenditures which she has not shown to be inconsistent with an approved plan); Maryland v. Mathews, 415 F. Supp. 1206 (D.D.C. 1976) (Secretary may not disallow Title IV-A expenditures which, though theoretically excessive, were practically unavoidable).

this Court. It is urgently presented by the decision below. Accordingly, the Court should issue the writ to review the decision of the Court of Appeals.

III. THE COURT'S REFUSAL TO APPLY PENNHURST'S CLEAR STATEMENT RULE, AND ITS DEFERRAL TO THE SECRETARY'S POST HOC DENIAL OF A FEDERAL OBLIGATION TO THE STATES, RAISES AN IMPORTANT FEDERAL QUESTION WHICH SHOULD BE REVIEWED BY THIS COURT.

In Pennhurst, the Court observed that legislation such as Title XIX, which is enacted pursuant to the spending power, is "in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions." 451 U.S. at 17. Consequently, the Court said,

> The legitimacy of Congress' power to legislate under the Spending Power thus rests on whether the State voluntarily and knowingly accepts the terms of the "contract." ... There can, of course, be no knowing acceptance if a State is unaware of the

> conditions or is unable to ascertain what is expected of it. Accordingly, if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously. ... By insisting that Congress speak with a clear voice, we enable the States to exercise their choice knowingly, cognizant of the consequences of their participation.

Id. at 17-18.

In the instant case, the Court of Appeals "[found] the statutory arguments presented on both sides equally balanced ...." Pet. App. at 32. The court refused, however, to apply the clear statement rule, and instead deferred to the Secretary's interpretation. The Court thought Pennhurst inapplicable to the resolution of minor or "interstitial" questions, or to the interpretation of existing conditions on the receipt of funds, as opposed to the determination whether a provision is a condition at all. Pet. App. at 29-30, 34. The court

found an analogy in Bell v. New Jersey, 461 U.S. 773, 790 n. 17 (1983), wherein this Court indicated that the Pennhurst rule might not be applicable to the determination of what remedies the federal government might have against states which concededly have misspent federal funds. Pet. App. at 30-31.

There is no merit to the court's suggestion that the dispute in this case concerns the remedies available to the federal government. To the contrary, the Commonwealth has assumed throughout this litigation that if it is not entitled to reimbursement under § 1396b(a) for its interim rate payments to nursing homes, then the Secretary may recover the federal share of those payments whether or not the Commonwealth makes recovery from the nursing homes. The dispute in this case thus concerns substantive

rights and obligations under § 1396b(a) -- the Secretary's obligation to pay, and the Commonwealth's right to be paid.

Further, contrary to the opinion below, this dispute does not concern a minor or interstitial question of law; rather, it concerns what this Court has identified as "the cornerstone of Medicaid," i.e., the availability of "federal financial assistance for all legitimate state expenditures under an approved Medicaid plan." Harris v. McRae, 448 U.S. at 308-09. As the Secretary's position and the decision below radically affect the obligation under § 1396b(a), they could scarcely cut more nearly to the core of this federal-state partnership.

In Bell v. New Jersey, 461 U.S. 773, (1983), the Court considered a claim that prior to 1978, the federal government

was without authority to recover funds under the Elementary and Secondary Education Act which had been misused by the states. While the Court found recoupment authority in the pre-1978 statute, it also suggested that the Pennhurst rule of construction might not apply to questions of remedy. Id. at 790 n. 17. That is very far from saying that the rule would not apply to questions of substantive right or obligation. Mr. Justice White noted the distinction and his own view that

> There is a significant issue whether a State can be required to repay if it has committed no more than a technical violation of the agreement or if the claim of violation rests on a new regulation or construction of the statute issued after the state entered the program and had its plan approved.

Id. at 794 (White, J., concurring). And, in Hendrick Hudson District Board of Education v. Rowley, 458 U.S. 176, 204 n.

26 (1982), the Court invoked the rule as an aid to determine the meaning of an acknowledged condition on federal grants under the Education for Handicapped Children Act, 20 U.S.C. §§ 1401 et seq.

Thus, the question whether the clear statement rule applies to the interpretation of statutory provisions establishing substantive conditions and obligations is a question which has been identified and which should be resolved by this Court.

The Court should resolve the question in this particular case for three additional reasons. First, it is exceptionally clear that the application of the rule would be dispositive of the case. The First Circuit repeatedly noted that the statute is ambiguous, and concluded that "the statutory arguments presented on both sides [are] equally balanced."

Pet. App. 23, 26, 32. Second, the underlying question is itself one of profound and lasting significance to the partnership established by Title XIX. See Argument I, supra.

Finally, the First Circuit's refusal to apply the clear statement rule appears to be in conflict with the view adopted by the Sixth Circuit in Kentucky Department of Education v. Secretary of Education, 717 F.2d 943 (6th Cir. 1983), cert. granted, 105 S. Ct. 78 (1984). There the Secretary of Education sought to recover funds paid under the Elementary and Secondary Education Act on the ground that they had been used in violation of a statutory condition that such funds not be used to supplant local funds. The court concluded that, although reasonable, the Secretary's test for whether federal funds had been used to supplant

local funds was not unambiguously supported by the statutes or regulations. Since the state's position was also reasonable under the statute, the Court reversed the Secretary's decision. Id. at 946-50.

If, as the Sixth Circuit held, the clear statement rule is applicable to the interpretation of an acknowledged grant condition,[23/] then the rule ap-

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23/ As previously noted, this Court has already invoked the rule as an aid in determining the meaning of an acknowledged grant condition. Hendrick Hudson Dist. Bd. of Educ. v. Rowley, 458 U.S. at 204 n. 26. The Kentucky case might be distinguished on the ground that the statute in Rowley was fundamentally ambiguous, while the ambiguity in the statute in issue in Kentucky concerned only the measure of compliance with a clear condition. But if such a distinction can be drawn, the instant case clearly falls on the Rowley side of the line, for there is no significant distinction between the imposition of a new condition, as in Pennhurst, or the imposition of a substantial new burden by interpre-

(footnote continued)

plies a fortiori in determining the extent of the Secretary's authority, if any, to disallow federal financial participation in expenditures authorized by a state plan. See also Perales v. United States, No. 83 Civ. 5850-CLB (S.D.N.Y., May 14, 1984), aff'd mem., No. 84-6249 (2d Cir., December 18, 1984) (declaring invalid, in the absence of clear statutory authorization, the assessment of interest against state agencies which delay repayment of federal funds under the Food Stamp program).

Not only did the Court of Appeals refuse to apply the clear statement rule, but it also determined that it was required to give the Secretary's interpre-

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(footnote continued)

tation of an acknowledged condition, as in Rowley, and the disavowal of the principal federal obligation under Title XIX, as in this case.

tation "significant weight." Pet. App. at 35. This element of the Court's decision also merits review by this Court.

In support of its decision, the Court of Appeals referred to the provision of § 1396b(d)(2) directing the Secretary to reduce payments on estimated state expenditures "to the extent of any overpayment ... which the Secretary determines was made." This provision, said the Court, "seemingly entrust[s] the determination of what constitutes an overpayment to the Secretary." Pet. App. 34 (emphasis added). But this amounts to a ruling that the Secretary is empowered to fix the federal government's substantive obligation to the states under § 1396b(a) after the states have already expended funds in accordance with their approved plans. Such a power is antithetical to the conception that a program such as

Title XIX is "in the nature of a contract." Pennhurst, 451 U.S. at 17. Indeed, the decision below in effect gives the Secretary the authority to "surpris[e] participating States with post-acceptance or 'retroactive' conditions," a power forbidden even to Congress. Id. at 25.

At bottom, the decision below betrays a confusion of the Secretary's roles under Title XIX. It may be granted that the Secretary enjoys regulatory authority under that program, but she exercises it in relation to the states only by virtue of their agreement to be so bound in return for partial federal reimbursement. The decision below enlarges this regulatory authority to include power to alter the very terms of the agreement from which the Secretary derives her authority.

Moreover, the decision compounds the confusion by giving retrospective effect to an exercise of regulatory control in a dispute over the Secretary's obligation to reimburse costs previously incurred. But as the court itself recognized, deference to the Secretary's views, not memorialized in regulations, is problematical in the context of a disallowance proceeding. See Pet. App. at 35. In that context, the Secretary's regulatory goals, if any, are subordinated to her pecuniary interest. It can scarcely be said that the retroactive imposition of a nonobvious interpretation upon the states, in a dispute over money, furthers a regulatory goal.[24/] See Kentucky De-

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24/ Furthermore, § 1396c appears to contemplate that such changes in federal policy be effectuated prospectively, as is usual with regulatory action. See

(footnote continued)

partment of Education v. Secretary of Education, 717 F.2d at 947 (in disallowance proceeding, reasonableness of Secretary's interpretation is not relevant; fairness to the state requires that such interpretation be given purely prospective effect).

Because the lower court's evident confusion concerns the "cornerstone" of Title XIX, see Harris v. McRae, 448 U.S. at 308-09, the question whether that court erred in refusing to apply the clear statement rule, and in deferring to the Secretary, merits review by this Court.

(footnote continued)

County of Alameda v. Weinberger, 520 F.2d 344 (9th Cir. 1975); Solomon v. Califano, 464 F.2d 1203 (D. Md. 1979).

Conclusion

For the reasons stated, the Court should issue a writ of certiorari to review the judgment of the United States Court of Appeals for the First Circuit.

Respectfully submitted,

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No. 84-

IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1984

THE COMMONWEALTH OF MASSACHUSETTS
by its DEPARTMENT OF PUBLIC WELFARE,
Petitioner,

v.

SECRETARY OF THE UNITED STATES
DEPARTMENT OF HEALTH AND
HUMAN SERVICES,

ADMINISTRATOR OF THE HEALTH CARE
FINANCING ADMINISTRATION,

and

THE DEPARTMENTAL GRANT APPEALS BOARD,
Respondents.

APPENDIX TO THE PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

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UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

No. 84-1197

THE COMMONWEALTH OF MASSACHUSETTS,
BY ITS DEPARTMENT OF PUBLIC WELFARE,

Plaintiff, Appellee,

v.

SECRETARY OF HEALTH AND HUMAN
SERVICES, et al.,

Defendants, Appellants.

APPEAL FROM THE UNITED STATES DISTRICT
COURT FOR THE DISTRICT OF MASSACHUSETTS
[Hon. W. Arthur Garrity, Jr.,
U.S. District Judge]

Before

Campbell, Chief Judge,

Bownes, Circuit Judge,

and Perez-Gimenez,* District Judge.

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*Of the District of Puerto Rico, sitting by designation.

November 28, 1984

CAMPBELL, Chief Judge. This appeal involves a dispute between Massachusetts and the Secretary of Health and Human Services ("the Secretary") over Massachusetts's right to be federally reimbursed for certain unrecovered advances to nursing homes. Procedural aspects of the dispute were previously before us in Massachusetts v. Departmental Grant Appeals Board, 698 F.2d 22 (1st Cir. 1983). We held there that 42 U.S.C. § 1316(a)(3) did not authorize direct review by a court of appeals of the challenged decision of the Secretary's Departmental Grant Appeals Board. The instant proceeding was then pending in the district court, Massachusetts having also sought review in the district court from the same agency ruling. See Massachusetts, 698 F.2d at 26. When denying direct court of appeals review, we anticipated

Massachusetts would proceed below, and that the losing party would eventually come to us on appeal. Massachusetts, 698 F.2d at 30. That appeal is now here, the district court having decided in favor of Massachusetts and against the Secretary in an opinion published at 576 F. Supp. 1565 (1984).

I. FACTS

The nature of this dispute is set out in our opinion in Massachusetts, 698 F.2d at 23-24. It arises under the Medicaid statute. 42 U.S.C. § 1396a entitles those states that choose to establish a Medicaid program and that submit to the Secretary a state plan fulfilling the requirements of the Medicaid statute and implementing regulations, to receive federal grants in partial reimbursement of expenses incurred in providing medical

assistance to Medicaid recipients. Federal grants are paid in advance of each quarter based on an estimate provided by the state. 42 U.S.C. § 1396b(d). After actual expenditures are determined, the federal grant for the next quarter is "reduced or increased by the amount of any overpayment or underpayment which the Secretary determines was made." Id. The controverted sums here are ones which the Secretary claims a right to recover as "overpayments," and which Massachusetts strenuously insists are not "overpayments."

To reimburse nursing homes and other health care providers for the medical assistance they render to medicaid recipients, Massachusetts employs a system of interim estimates, sometimes called "retrospective rate-setting." Under this

system (which some but by no means all states employ), Massachusetts begins by setting an interim rate for each provider based on the provider's costs during the previous year. Utilizing this interim rate, Massachusetts then advances to the provider an interim amount at the beginning of each month for the estimated cost of services to be provided that month. Mass. Gen. Laws ch. 6A, § 32. At the close of the rate year, the Massachusetts Rate-Setting Commission performs a complete desk audit of the provider's cost reports, supplemented when necessary by an on-site audit of the provider's books and records, Mass. Admin. Code tit. 114.2, § 2.04(4), to determine the provider's actual costs. A final rate is then set which, if lower than the interim rate, causes Massachusetts to owe to the

provider a smaller amount than it advanced in the past year. Massachusetts undertakes to recover any such differential in its favor by billing the provider or by making offsets against subsequent interim payments. See Mass. Admin. Code tit. 106, § 456.701-.704.

Federal quarterly grants reflect Massachusetts's retrospective rate-setting approach. Thus Massachusetts initially receives from the federal government an amount based on the Commonwealth's interim disbursements to providers. Subsequent grants will reflect any adjustments deemed appropriate in light of final provider rates. In the past, Massachusetts has not reported amounts attributable to any retroactive rate decrease as a decreasing adjustment to the next quarter's federal grant until

it actually recovers the differential from the provider. This practice is in keeping with its view that no "overpayment" has occurred until the state actually recovers the excess amount from the provider.

The instant dispute arose when the Massachusetts Department of Public Welfare ("the Department") failed to recover from certain providers the difference between what it had paid them on the basis of interim rates and the lesser amounts owed to the same providers under smaller final rates. Massachusetts failed to recover because these providers had become bankrupt or were otherwise unable or unwilling to meet their repayment obligations after the final rates took effect. Notwithstanding Massachusetts's inability to recover these

sums,[1] the Secretary insisted that the Commonwealth owed them to her as "overpayments" within the meaning of 42 U.S.C. § 1396b(d)(2). It was and is the Secretary's position that grants to a state under the Medicaid program are limited to the costs incurred for "medical assistance"; and that since these costs are most accurately determined under Massachusetts's retrospective system by the state's own final rates, any overage which the Secretary advanced under less precise interim rates becomes a recoverable overpayment once a final rate is set whether or not the state itself ever recovers it from a provider.

1/ The exact amount at stake in this dispute is unclear. Each party, as well as the district court, cites to a somewhat different figure, but the question of the precise sum is not an issue in this appeal, and we need not try to resolve the disparity.

Massachusetts vigorously protests the Secretary's interpretation. It denies that the sums paid to providers under interim rates are "overpayments," insisting instead that they are a legitimate cost of providing medical assistance until the state itself recoups any differential between the later, final rates. It notes that the Secretary has acquiesced in the Massachusetts system of retrospective rate-setting by her willingness to base initial federal payments on the interim rates. While Massachusetts agrees that it must reimburse the Secretary for all sums actually recovered from providers reflecting the final rates, it contends that it owes no reimbursement for amounts which, in good

faith, it cannot recover.[2]

2/ Each party has an immediate statutory basis for its claim. The Secretary relies on section 1396b(d)(2) which provides as follows:

> (2) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection. . . .

Massachusetts, on the other hand, relies on section 1396b(d)(3) which reads,

> (3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

In Massachusetts's view, the mere refer-

(footnote continued)

II. PRIOR PROCEEDINGS

This case originated from an audit by HHS's Health Care Financing Administration ("HCFA") of the accounts receivable ledgers of the Massachusetts Department of Public Welfare for the period between April and November 1979. Upon discovering a substantial number of unrecovered excess payments to nursing

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(footnote continued)

ence in section 1396b(d)(2) to "overpayment" does not empower the Secretary to treat the challenged sums as an overpayment. While (d)(2) authorizes the Secretary to reduce a quarterly grant by "any overpayment or underpayment which the Secretary determines was made . . . ," (emphasis supplied), Massachusetts nonetheless argues that the Secretary lacks any right to view the state's unrecovered excess provider payments as such an "overpayment." Only when the state actually recovers the overage from the provider, so that it now conforms to section 1396b(d)(3), does it become a cognizable "overpayment" in the state's view. Until that time, since the state like its partner, the federal government, is out-of-pocket, the state has not -- in this view -- been "overpaid."

homes made under interim rates, HCFA informed Massachusetts that it had determined to disallow Massachusetts's claim for federal financial participation to the extent of that excess, and would reduce HHS's next quarterly grant to Massachusetts by like amount. Massachusetts appealed this disallowance to the Departmental Grant Appeals Board of HHS, which, on February 26, 1982, sustained the disallowance. Departmental Grant Appeals Board Decision 262, No. 80-54-MA-HC (Feb. 26, 1982). On April 22, 1983, Massachusetts brought the action now before us in the United States District Court for the District of Massachusetts pursuant to 5 U.S.C. § 702. The district court disagreed with the Board. 576 F. Supp. at 1568.

The court found that section 1396b(d), the statute governing overpay-

ments, see note 2, supra, was ambiguous, since it did not define the term "overpayments." 576 F. Supp. at 1568. The court felt that either section 1396b(d)(2), which directs the Secretary to reduce the amount of her quarterly grants to a state by the amount of any prior overpayment, or section 1396b(d)(3), which entitles the Secretary to treat as an overpayment her share of medical assistance payments recovered by the state, could on its face govern the amount at issue. Id. The court went on to conclude that the Secretary had presented no evidence to support her characterization of the differentials as section 1396b(d)(2) overpayments. Id. Relying on Harris v. McCrae [sic], 448 U.S. 297 (1981), the Court ruled that the general intent of Congress in enacting the Social Security Act was to create a part-

nership between the states and the federal government in defraying Medicaid costs. Therefore, the Secretary was obliged to bear her share of the loss, since the interim payments giving rise to the supposed overpayments had been made in accordance with a plan that the Secretary had approved. 576 F. Supp. at 1568-69.

III. ARGUMENTS ON APPEAL

The Secretary argues on appeal that the Medicaid statute clearly contemplates that she recover from Massachusetts, as an overpayment, the federal share of the difference between the interim and final rates of reimbursement by Massachusetts to health care providers. She points to 42 U.S.C. § 1396b(a), which provides that "the Secretary shall pay to each State which has a plan approved under this

subchapter . . . (1) an amount equal to the Federal medical assistance percentage . . . of the total amount expended during such quarter as medical assistance under the State plan." (Emphasis supplied.) "Medical assistance" is defined in section 1396d(a) as "payments of part or all of the cost of [certain enumerated] care and services," including "skilled nursing facility services." Since Massachusetts ultimately determined that the interim rate at which it reimbursed health care providers was higher than their actual cost of providing health care, so the Secretary argues, the difference is not a cost of "skilled nursing facility services," and so not a cost of medical assistance. Therefore, the Secretary is not required by section 1396b(a) to pay any part of the differ-

ence between Massachusetts's interim and final rates, and indeed is required by section 1396b(d)(2) to subtract her share of that difference from subsequent grants since that difference is an overpayment.

The Secretary's argument turns on the meaning of "cost," a word the statute leaves undefined. The Secretary contends that the rate differentials at issue here are not part of the "cost" of medical assistance, and hence are overpayments. In reaching this result, she argues that two provisions of the Medicaid statute are in pari materia with section 1396d(a) and hence aid in the interpretation of the word "costs." Those provisions are section 1396a(a)(13)(E) as it existed at the time the payments in dispute were made, which requires a state to set rates to nursing homes on a "reasonable cost

related basis," and section 1396a(a)(30), which requires state plans to provide for methods of payments that will assure that payments "are not in excess of reasonable charges consistent with efficiency, economy, and quality of "care." The Secretary argues that these provisions indicate that "cost" as it is used in section 1396d(b) should be construed to mean the cost of care to the providers rather than -- as in the case of unrecovered payments -- the cost of care to the state.

To fortify her construction of the statute, the Secretary insists that as the official authorized by Congress to carry out the Medicaid program, her interpretation of the Medicaid statute is entitled to judicial deference. The Secretary suggests that her argument for

judicial deference is strengthened by the existence of a number of long-standing regulations that govern the recovery of overpayments, see 20 C.F.R. § 201.5(a)(3), .13-.15, and that require her to treat the rate differentials as overpayments.

Massachusetts's contrary argument begins with the same statutory language as the Secretary's. Massachusetts, too, points out that section 1396b(a) directs the Secretary to pay her share of the "amount expended . . . as medical assistance under the State plan." The rate differentials meet both conditions, Massachusetts argues: they were part of the state's cost of medical assistance and, at the time the interim expenditures were made, the amounts were paid out in accordance with a system of prospective rate-setting embodied in Massachusetts's

federally approved state plan. Under Massachusetts's argument, it is immaterial that the interim rate is later found to be in excess of the provider's cost. What is relevant, in its view, is Massachusetts's cost, and here its out-of-pocket expense remains the interim amount it paid out until such time as it may be reimbursed by a provider. Massachusetts cites for its interpretation Massachusetts General Hospital v. Weiner, 569 F.2d 1156, 1158 (1st Cir. 1978), which states that prior to 1972, when standards for the reimbursement of nursing homes were added to the section 1396a requirements for state plans, the word "cost" in the context of section 1396a had meant "costs actually incurred," and that this was the understanding of Congress in drafting section 1396d. Massachusetts

also cites without explanation a number of HHS regulations in effect during the years in question in support of its interpretation of the word "cost." See 42 C.F.R. § 447.252(a), (c), .315(a), .316(a) (1979).

Massachusetts contends that, because the rate differentials were part of the "amount expended . . . as medical assistance under [its] State plan," for the Secretary to deny federal reimbursement for her share of the differentials would amount to the imposition of an additional unauthorized condition on Massachusetts's receipt of federal Medicaid funds beyond those revealed to Massachusetts at the time it agreed to participate in Medicaid. Such an imposition would violate the principle announced in Pennhurst State School v. Halderman, 451 U.S. 1

(1978), that any conditions imposed on the receipt of federal funds by the states be imposed clearly and unambiguously. In support of her contention that the obligation of the Secretary to reimburse is absolute where not expressly conditioned, Massachusetts cites section 1396b(u)(1)(A), which states that the Secretary is barred from reimbursing payments made to ineligible persons where those payments exceed three percent of the total grant to the state "notwithstanding subsection (a)(1)," the subsection imposing the general obligation to reimburse.

As did the district court, Massachusetts also relies upon Harris v. McCrae [sic], 448 U.S. 297, in support of its argument that the federal government is obliged to reimburse the state for its share of the unrecovered rate differen-

tials. In Harris, the Supreme Court described Medicaid in general terms as a partnership between the states and the federal government. According to Massachusetts, this partnership concept requires the Secretary to foot her share of the bill for the differentials.

Finally, Massachusetts contrasts the rule-making authority granted the Secretary under certain sections of the welfare statute -- for example, section 1396a(a)(17)(B), which requires a state plan to make certain payments under "standards prescribed by the Secretary" -- with section 1302, which states that the Secretary "shall make . . . rules and regulations, not inconsistent with this chapter, as may be necessary to the efficient administration" of her functions. Massachusetts concludes that

though the Secretary is entitled to some deference in her interpretation of the statute, she cannot be allowed to interpret it in a manner inconsistent with its letter, as provided in section 1396b(a), and its spirit as portrayed in Harris.

IV. DISCUSSION

While both sides contend that their interpretation of the Medicaid statute is alone reasonable, the statute, as often happens, is itself less than crystal clear. While the question is close, we are persuaded the Secretary is entitled to prevail.

First, the Secretary's construction that the "cost" of medical assistance is measured by the allowable providers' costs, and does not include reimbursement for excess, unrecovered interim advances, seems to us at least as reasonable as

Massachusetts's contrary interpretation. It is true, as Massachusetts points out, that the cost to Massachusetts of obtaining health care services from providers who went bankrupt before Massachusetts could recover the rate differentials is the cost as determined at the interim rate; that is the amount that Massachusetts actually paid out. However, it can be said that the fair and reasonable cost of those services is the cost as determined in the final rate, and that Congress could scarcely have meant to reimburse a state for excessive cost of services. While the Secretary allows Massachusetts to use a rate-making system which exposes the state to the risk of loss when a provider defaults, the Secretary arguably does not thereby guarantee the state's bad debts. No custom has

been shown, in other Medicare contexts, for federal grants to reimburse a state for losses due to bad debts of this type. Cf. 42 C.F.R. § 447.282 (1979) (state plan generally may not provide for the reimbursement of nursing homes for the homes' bad debts).

To be sure, the Secretary has not pointed to regulations or statutory language lending definitive support to her position. The regulations that she cites, 20 C.F.R. § 201.5(a)(3), .13-.15, all concern when and how the Secretary shall recover overpayments, not whether the rate differentials at issue here are or are not overpayments. And, one of the two statutory subsections she says are in pari materia with section 1396d(a), section 1396a(a)(30), refers to "charges," not "costs." The other, section 1396a(a)(13)(E) as it existed

during the relevant years, which provided that payments to nursing care providers made under the state plan be on a "reasonable cost related" basis, is arguably not inconsistent with Massachusetts's receiving federal reimbursement for payments made to providers at the interim rates, since it can be asserted that those rates were set on a reasonable cost related basis.

On the other hand, the support for Massachusetts's position is likewise inconclusive.

First, the HHS regulations that Massachusetts cites, 42 C.F.R. § 447.252(a), (c), .315(a), .316(a) (1979), simply set ceilings on the amounts that a state plan may disburse to providers. They thus seem to set necessary but not sufficient conditions for Massachusetts's obtaining federal financial participation for its

expenditures. See 42 C.F.R. § 447.252(c) (1979) (federal financial participation is "available" for expenditures within limits).

Second, Massachusetts General Hospital v. Weiner, 569 F.2d 1156 (1st Cir. 1978), the case cited by Massachusetts for the proposition that the word "cost" meant "amount actually expended" at the time section 1396d was enacted, states that proposition without authority and in dicta. The reference is simply too insignificant to be persuasive in this context.

Third, we find both Harris and Pennhurst inapposite. In Harris, the Supreme Court stated that "[t]he cornerstone of Medicaid is financial contribution by both the Federal Government and the participating State," and that "the purpose

of Congress in enacting Title XIX was to provide federal financial assistance for all legitimate state expenditures under an approved Medicaid plan." Harris, 448 U.S. at 308-09. The issue raised in Harris, however, was whether the states should be required to pay in full for abortions, the cost of which the Secretary was forbidden by statute from contributing to. Harris thus attributes to Congress the intention that no state should be obliged by the Medicaid statute to pay for a service unless the Secretary pays her share, not that the Secretary must pay her share of every out-of-pocket state expense no matter how incurred.

Similarly, Pennhurst differs in crucial respects from the case at bar. In Pennhurst, the statute being construed, the Developmentally Disabled Assistance

and Bill of Rights Act of 1975, 42 U.S.C. §§ 6000 et seq. (1982), contained both a list of specific conditions on the receipt of federal funds and a broad "bill of rights" provision that set out the findings supporting the goals of the Act. The Court held that the latter's statements were merely precatory, imposing no additional obligations on states receiving federal funds under the Act. The present case involves the construction and enforcement of a narrow statutory provision, 42 U.S.C. § 1396b(d). We do not believe that Pennhurst requires that every arguably ambiguous provision conditioning the receipt of federal funds by a state be construed in the state's favor. This conclusion seems supported by the logic of Pennhurst itself. Pennhurst found the imposition of new condi-

tions on the receipt of federal funds repugnant to the notion that by accepting the funds the state had thereby entered into a contract with the federal government and was entitled to have its bargain enforced as written. Pennhurst, 451 U.S. at 17. The present case involves not the imposition of a new condition on the state but the interpretation of the provisions governing the remedies available to the federal government. No principle of contract law requires us to construe such a provision consistently against a federal government obligee. Indeed, in a similar setting, the Supreme Court declined to apply Pennhurst to the construction of an arguably ambiguous provision governing the right of the Secretary of Education to recover federal funds that the state had misspent. Bell

v. New Jersey, 51 U.S.L.W. 4647, 4651-52 n.17 (May 31, 1983).

Whether section 1396b(d)(2) or section 1396b(d)(3) should govern the rate differentials here -- or, in other words, whether the Secretary must wait until a state recovers the differentials before she can recover her share from the state -- is at least unclear, as the district court believed. Whether the differentials are to be covered under section 1396b(d)(2) or (d)(3) boils does [sic] to whether one thinks they are more like those expenses acknowledged to be overpayments, e.g., payments to ineligible recipients, see Medical Services Administration v. United States, 590 F.2d 135 (5th Cir. 1979), or payments to physicians in excess of ceilings established in the state plan, see Georgia v. Cali-

fano, 446 F. Supp. 404 (N.D. Ga. 1977), or are more like those not recoverable by the Secretary until recovered by the state, e.g., Medicaid payments for services already covered by an insurer, see section 1396b(d)(2), second sentence, or payments recovered from a recipient's estate.

Because we find the statutory arguments presented on both sides equally balanced, we turn to considerations of administrative and legislative policy, and here there are at least two reasons to side with the Secretary in this dispute.

First, as the question presented here is one concerning which Congress has given no definitive direction, we believe that it is appropriate to attach some weight to an agency's interpretation of

a statute that it is responsible for administering, that interpretation being both reasonable and statutorily permissible.[3/] This rule is strengthened where Congress has given the administrator explicit rule-making authority, see id., and where the question presented is more concerned with the efficient administration of a program entrusted to the Secretary than with broad questions of policy. As Judge Breyer stated for this court in the recent case of Mayburg v.

3/ See Chevron, U.S.A., Inc. v. National [sic] Resources Defense Council, Inc., 52 U.S.L.W. 4875, 4877 (June 25, 1984). Chevron involved, it is true, a rule-making. But the Chevron Court cited in support of its principle INS v. Jong Ha Wang, 450 U.S. 139 (1981), a case upholding the INS's interpretation of the Immigration and Naturalization Act in a deportation proceeding. See Chevron, 52 U.S.L.W. at 4877 (citing Jong Ha Wang, 450 U.S. at 144). Hence we think the principle is also applicable in an adjudicatory setting, as here.

Secretary of HHS, No. 84-1022, slip. op. (1st Cir. Aug. 2, 1984),

> [t]he less important the question of law, the more interstitial its character, the more closely related to the everyday administration of the statute and to the agency's (rather than the court's) administrative or substantive expertise, the less likely it is that Congress (would have) "wished" or "expected" the courts to remain indifferent to the agency's views.

(Citations omitted.)

Section 1396b(d)(2), moreover, itself commands that federal grants be reduced "to the extent of any overpayment . . . which the Secretary determines was made" (emphasis supplied), thus seemingly entrusting the determination of what constitutes an overpayment to the Secretary. Massachusetts argues that 42 U.S.C. § 1302, the rule-making authority relied on by the Secretary, only empowers her

to make rules "not inconsistent with this chapter," but since we are unable to say that the Secretary's position is inconsistent with the statute, we do not find that argument persuasive. We believe that with respect to matters of this character, where the statute is not explicit, Congress would have intended the Secretary's construction to be given significant weight.

To be sure, the Secretary's obvious pecuniary stake in this case is bound to heighten our scrutiny of her reading of the statute, but the same interest can be found in most cases involving the federal financial participation provisions of the welfare statutes.

Second, the weight of policy seems to us to fall on the side of the Secretary's interpretation. Since Medicaid

is a joint program of the state and federal governments for providing health care, it is appropriate to inquire whether imposing that portion of the rate differential at issue on Massachusetts or the Secretary will better conserve the limited pool of resources available for that purpose. Since only Massachusetts deals directly with the providers, and since the state is empowered to perform on-site audits of these institutions, it is clearly the party best able to minimize the risks resulting from dealing with insolvent providers. The fact that Massachusetts will in any event bear a share of the loss, and so already has some incentive to minimize these risks, diminishes but does not destroy the force of this observation. Placing an additional burden on the state will

increase its incentive to take care, whereas the Secretary remains powerless to reduce the risks no matter what the costs imposed on her.

Additionally, we find some force in the Secretary's argument that while the Secretary accepts Massachusetts's retrospective rate-setting scheme, it does not thereby agree to underwrite provider defaults. The latter are an unintended by-product of the scheme, not an explicit expense. The Secretary may reasonably feel that it is more in keeping with sound administration to gear reimbursement to the fair cost of the providers' services -- a yardstick more generally applicable in all states, many of which have different systems for determining and reimbursing provider costs.

The judgment of the district court

is reversed. We also direct that judgment now be entered in appeal No. 82-1364.

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

CIVIL ACTION NO. 82-1048-G

COMMONWEALTH OF MASSACHUSETTS by its Department of Public Welfare,

Plaintiff

vs.

MARGARET HECKLER, ET AL,

Defendants

J U D G M E N T

GARRITY, J.

In accordance with the Court's "Memorandum and Order that Judgment be Entered for Plaintiff" entered on January 12, 1984, it is ORDERED:

> that the decision by the Departmental Grant Appeals Board sustaining HHS' disallowance of the $3,703,098 be reversed and set aside, pursuant to 5, USC, §706, that plaintiff's motion for summary judgment is granted

and it is FURTHER ORDERED:

that judgment for the plaintiff declaring that the plaintiff's interim payments to IDAK et al. nursing homes were not, under the attendant circumstances, overpayments within the meaning of 42 USC §1396(d)(2) be, and it is hereby, entered.

By the Court:

STEPHEN A. MOYNAHAN, JR.
Deputy Clerk

Dated: January 13, 1984

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

CIVIL ACTION NO. 82-1048-G

COMMONWEALTH OF MASSACHUSETTS by its Department of Public Welfare,

Plaintiff

v.

MARGARET HECKLER, ET AL.,

Defendants

MEMORANDUM AND ORDER THAT JUDGMENT BE ENTERED FOR PLAINTIFF

January 12, 1984

GARRITY, J.

In this action the Commonwealth of Massachusetts (Commonwealth) seeks judicial review, pursuant to 5 U.S.C. § 702, of a final decision of the Departmental Grant Appeals Board (GAB) of the Department of Health and Human Services (HHS). The GAB disallowed approximately $3.7

million in federal Medicaid reimbursement to the Commonwealth to offset a prior overpayment of $3.7 million. The Commonwealth also seeks declaratory and injunctive relief, pursuant to 5 U.S.C. §§ 702, 703 and 28 U.S.C. § 2201, to determine the rights and obligations of the Commonwealth under the Medicaid program, 42 U.S.C. § 1396b et seq., and to prevent the withholding of the federal funds.

The dispute arose following a routine audit of the accounts receivable ledgers of the Commonwealth's Department of Public Welfare (DPW) by the Health Care Financing Administration (HCFA). This agency is a part of HHS, and is responsible for administering the Medicaid program at the federal level. The audit not coincidentally followed the filing in bankruptcy of 27 nursing homes (IDAK

et al) which had been receiving Medicaid payments. On February 21, 1980, HCFA issued its decision that the Commonwealth had overpaid these nursing homes by more than $10 million, so that the Commonwealth owed HHS $5,115,610. This amount represents the amount paid to the Commonwealth by HHS in excess of the final rate, less the amount which had been repaid by the Commonwealth to HHS. HHS was authorized by HCFA to offset this amount against Federal Financial Participation (FFP) owed to the Commonwealth. This offset procedure is known as a disallowance.

The Commonwealth timely appealed this decision to the GAB, which on February 26, 1982 sustained the disallowance and directed the parties to resolve the question of the exact amount owing to HHS.

This was finally accomplished on June 30, 1983, the amount being $3,703,098, but pending this appeal no adjustment has been made to the amounts paid to the Commonwealth.[1/]

On April 22, 1982, the Commonwealth filed actions appealing the GAB's decision in both this court and the United States Court of Appeals for the First Circuit. On August 20, 1982, defendant HHS filed a motion to dismiss in our court. We stayed our decision on this motion pending the decision by the Court of Appeals. On January 12, 1983, the appellate court held that it was without

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1/ Defendant had moved to dismiss for failure to exhaust administrative remedies and for lack of ripeness for judicial review. Both these motions have been mooted by the final administrative determination of the amount owing, and were withdrawn at the hearing.

jurisdiction to hear the case, rejecting plaintiff's argument that this was a "noncompliance" case rather than a disallowance suit. Had it been the former, the Court of Appeals would have had jurisdiction under 42 U.S.C. § 1316(a)(3). The court explained the difference between the two concepts as follows:

> Disallowances typically involve a denial of FFP [Federal Financial Participation] for a narrow item or class of items, and do not, in some general sense, affect the working of the program or federal-state cooperation. Whereas a finding of noncompliance can (although it need not) lead to the cessation of federal participation altogether, a disallowance is merely a retrospective refusal to share in an unauthorized expenditure.

No. 82-1364 at 10. The court found that this was not a compliance matter since it merely involved a dispute over "specific excess payments in certain limited

circumstances, and not . . . the state's overall ratesetting or payment methodology." No. 82-1364 at 21. Were the failure to reimburse HHS its share of excess payments itself to constitute noncompliance, then this would render meaningless the distinction between noncompliance actions and disallowance actions. Since 42 U.S.C. § 1316(a)(3) granted jurisdiction to the Court of Appeals only in noncompliance actions, the court held that it lacked jurisdiction to review the GAB's disallowance decision. It withheld its judgment until further notice, however, so as not to put the Commonwealth in the awkward position of being forced to challenge the ruling by petition for certiorari to the Supreme Court before knowing whether it could obtain review in the district court. The court

authorized the district court to act in related proceedings notwithstanding that judgment has yet to be entered.

On November 30, 1983, we heard argument on defendant's motion to dismiss. Defendant did not press its motion to dismiss for lack of jurisdiction. However, even where jurisdiction is uncontested, it is the court's responsibility to determine whether it has jurisdiction. We hold that it does. County of Alameda v. Weinberger, 9 Cir. 1975, 520 F.2d 344, Woodstock/Kenosha Health Center v. Schweiker, 7 Cir. No. 82-2375, decided July 19, 1983.

The remaining issue is whether plaintiff has failed to state a claim upon which relief may be granted. This turns on whether HHS has correctly interpreted the Medicaid provisions of the Social

Security Act, 42 U.S.C. § 1396 et seq., and in particular, the word "overpayment" in 42 U.S.C. § 1396b(d). To comprehend the arguments of the parties it is worthwhile to review the workings of the Medicaid program.

The Medicaid program is a retrospective reimbursement system under which the state DPW makes provisional payments to health care providers (in this case, nursing homes) at "interim rates" established by the Massachusetts Rate Setting Commission. These rates are based on the amount to which the provider was entitled in previous years. Each quarter, HHS reimburses the Commonwealth at approximately 50% of the interim rate. This reimbursement is called Federal Financial Participation (FFP). Following the close of the rate year, the Commis-

sion establishes a "final rate" based upon the actual costs of the provider during that year. If the final rate exceeds the interim rate, then the health care provider is entitled to receive further payment from the Commonwealth. If, on the other hand, the final rate is lower than the interim one, the Commonwealth is entitled to recover the difference. The issue at hand is whether the Commonwealth should be required to refund HHS its share of this excess whenever the situation occurs, or whether its obligation to refund HHS's share arises only after it obtains repayment by the health care provider.

Surprisingly, there does not appear to be any case law on this subject, and the Medicaid Act itself is ambiguous. The applicable provision, 42 U.S.C.

§ 1396b(d), states in pertinent part as follows:

> (d)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a state will be entitled under subsections (a) and (b) of this section for such quarter . . . .
>
> (2) The Secretary shall then pay to the state . . . the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under the section to such state for any prior quarter and with respect to which adjustment has not already been made under this subsection. Expenditures for which payments were made to the state under subsection (a) of this section shall be treated as an overpayment to the extent that the state . . . has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1396a(a)(25) of this title.2/ (emphasis supplied).

2/ § 1396a(a)(25) provides in essence that where a third party is legally liable to pay for the care and services

(footnote continued)

> (3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the state . . . with respect to medical assistance furnished under the state plan shall be considered an overpayment to be adjusted under this subsection.

A careful reading of the statute exposes the ambiguity. The first sentence of § 1396b(d)(2) permits the Secretary to reduce the amount of FFP to the extent of any overpayment for any prior quarter; § 1396b(d)(3) indicates, however, that certain payments are not to be considered overpayments until the state has recovered the money from the health care provider. Since the term "overpayment" is

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(footnote continued)

available to an individual under the state plan, and this liability was discovered after the medical assistance was made available, the state must seek reimbursement.

nowhere defined in the statute nor in the regulations, it is not clear which subsection applies in the present case.

In support of its position that § 1396b(d)(2) applies, defendant HHS contends that its obligation to reimburse states for medical expenses only covers expenditures based on the final rate; for it is the final rate that corresponds to what the state has determined to be the proper charge for services. Therefore, defendant argues, when a state pays a provider at an interim rate which is higher than the final rate, and HHS reimburses the state for part of that payment, HHS is entitled to disallow its share of the excess over the final rate as an overpayment since that amount was not properly expended by the state for medical assistance under the state plan. HHS also points to various regulations

which establish the authority of the Secretary to disallow improper payments without any condition that the state first recover the money from the provider.

HHS is correct in stating that where there is an overpayment, there need be no recovery by the state before the overpayment can properly be disallowed. However, HHS has not provided any evidence to establish that payment to a state at a higher interim rate than final rate constitutes an overpayment for purposes of § 1396b(d)(2). In the absence of such proof and in light of the policies underlying the Medicaid Act, we do not accept HHS' position.

In our view, to place the full burden of unrecoverable medicaid payments on the states would be inconsistent with the general scheme of the Medicaid pro-

gram, which was intended to function as a partnership between the states and the federal government. As the Supreme Court explained in Harris v. McRae, 1981, 448 U.S. 297, 308-309:

> The cornerstone of Medicaid is financial contribution by both the Federal Government and the participating State. Nothing in Title XIX as originally enacted, or in its legislative history, suggests that Congress intended to require a participating state to assume the full costs of providing any health services in its Medicaid plan. Quite the contrary, the purpose of Congress in enacting Title XIX was to provide federal financial assistance for all legitimate state expenditures under an approved Medicaid plan. (emphasis added)

Where a state pays a provider at an interim rate in accordance with its state plan, that is a legitimate expenditure for which we believe it is entitled to receive federal financial assistance. If it later turns out through no fault of the state that the interim rate was

higher than the final rate, the prior payment does not suddenly become improper, at least not where HHS approved the plan chosen by the state and the interim payment in question was made in compliance with the plan.

In the event that the state recovers the excess payment from the provider, the pro rata share of HHS in that recovery will be considered an overpayment under § 1396b(d)(3). Until such recovery occurs, however, HHS is not entitled to treat its payments to a state at an interim rate in excess of the final rate as overpayments. Therefore there are no grounds for disallowing the $3,703,098 in federal funds to the Commonwealth. Accordingly, it is ordered that defendant's motion to dismiss or in the alternative for summary judgment be denied, that the decision by the Departmental

Grant Appeals Board sustaining HHS' disallowance of the $3,703,098 be reversed and set aside, pursuant to 5 U.S.C. § 706, that plaintiff's motion for summary judgment be granted and that judgment be entered for the plaintiff declaring that the plaintiff's interim payments to IDAK et al. nursing homes were not, under the attendant circumstances, overpayments within the meaning of 42 U.S.C. § 1396b (d)(2).

W. ARTHUR GARRITY, JR.
United States District Judge

DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: Massachusetts Department of Public Welfare
Docket No. 80-54-MA-HC
Decision No. 262

DATE: February 26, 1982

DECISION

The Massachusetts Department of Public Welfare appealed a decision by the Health Care Financing Administration, denying $5,115,610 in federal financial participation (FFP) claimed under the Medicaid program. The disallowance represented the federal share of excess payments to certain nursing homes. The excess payments arose because the State paid each nursing home at an interim rate of reimbursement higher than the final rate established by the State. The State had not recovered the excess payments from the providers, which were bankrupt or no longer participating in the Medi-

caid program.

The State's major argument was that its method of reimbursement, approved by the Agency, necessarily resulted in such excess payments and, therefore, the Agency could adjust for the federal share in the payments only if the State recovered them from the providers. For the reasons stated below, we conclude that the Agency correctly determined that the excess payments were not allowable Medicaid costs and, therefore, FFP in the payments constitutes an overpayment to the State to be adjusted under section 1903(d) of the Social Security Act. Since the State has already adjusted for some of the excess payments, however, we remand to the Agency for the purpose of recalculating the disallowance.

Our decision is based on the written record and briefs.

General Background -- The State's Rate Setting Methodology

Title XIX of the Social Secuirty Act provides for the payment of federal monies to states to aid in financing state medical assistance programs. Any state that wishes to participate in the Medicaid program must develop and submit a plan that meets certain requirements set forth by the Secretary of HHS. Realizing that many states might have difficulty financing a Medicaid program even if subsequently reimbursed by the federal government, Congress also established a funding mechanism by which HHS advances funds to a state, on a quarterly basis, equal to the federal share of the estimated cost of the program. After review of the State's quarterly statement of expenditures, the Secretary may adjust future payments to reflect any overpay-

ment or underpayment which was made to the State for any prior quarter.

Congress gave the states discretion, subject to the Secretary's approval, in formulating an appropriate rate methodology to reimburse providers of Medicaid services. Responsibility for determining the rate at which Medicaid payments for nursing homes will be made in Massachusetts was delegated in the State plan to the Massachusetts Rate Setting Commission (RSC). Paralleling the federal government's method of reimbursing the states under the Medicaid program, Massachusetts developed a system whereby the providers of Medicaid services initially receive compensation at an interim rate.

The RSC sets the interim rate of payment, based on the provider's costs incurred during the previous year, adjusted

for factors such as inflation. The State then releases monthly payments for services rendered during the current year at that rate. This method of estimating ordinarily results in a rate which needs adjusting. Therefore, the actual cost of the services is evaluated at a later date based on a cost report for that year. The RSC audits the cost report for the purpose of establishing a final rate for the reporting period. This may lead to a final rate which is different from the interim rate at which payments were actually made to a provider during the reporting period.[1/]

1/ Although the State did not use precisely this methodology for the entire period in which these excess payments were made, previous systems also gave

(footnote continued)

If the RSC determines that the provider's reasonable, necessary and proper per diem cost of providing services is greater than the interim rate, the provider will have been underpaid. If the provider's cost of services is less than the interim rate, the provider will have been overpaid. A difference between the interim rate and the final rate necessitates a retroactive rate adjustment. The RSC files each retroactive rate adjustment with the Secretary of State.

An office within the DPW, the Retroactive Nursing Home Unit (RNHU), maintains a file for each provider. This file contains copies of all rate adjust-

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(footnote continued)

rise to a need for adjustments, and to possible excess payments. The State has pointed to nothing which would make our legal analysis less applicable to these earlier excess payments.

ments filed with the Secretary of State by the RSC and records showing the amount of underpayment or overpayment which each adjustment produces. If the final rate is lower than the interim rate and a retroactive rate adjustment is required, RNHU calculates the amount attributable to the decrease and records that amount on an Account Receivable Ledger Card. The sum of the amounts shown on a provider's Account Receivable Ledger Card represents the total amount that the RNHU will seek to recover from the provider. If a provider disputes the final rate determination, it may seek administrative review of the final rate by the State office of hearing examiners.

Case Background

As a result of reviews by the Financial Branch of HCFA's Regional Office, HCFA concluded that the State was not

accounting in a timely manner for unrecovered "overpayments" to providers which had received payments at an interim rate higher than a final rate filed by the RSC. The reviewers determined that these "overpayments" should have been accounted for on the State's quarterly statements of expenditures, within two quarters following the quarter in which found, in accordance with 42 CFR 447.296. The results of the reviews were discussed with State agency officials. The amounts disallowed were determined by reviewers who examined the Account Receivable Ledger Cards, maintained by the RNHU. Based on these State records, the Agency disallowed $2,768,367 identified as the federal share of overpayments to bankrupt providers and $2,347,243 identified as the federal share of overpayments to provi-

ders no longer participating in the program.

The Agency cited as a basis for the disallowance the regulation at 42 CFR 447.296, as well as section 1903(d)(2) of the Act. Attached to the disallowance letter was a schedule showing the amounts of the overpayments allegedly made to each provider involved, identifying the provider by number. The amounts were not shown as being related to any specific quarter, although they were identified as overpayments not recovered as of September 30, 1979.

On appeal to the Board, the State raised a number of substantive and procedural arguments. For purposes of this decision, we have discussed the substantive issues under these major headings:

I. Whether the excess payments are overpayments under the statute regardless of recovery.

II. Whether the Agency's regulations are valid and require adjustment for these excess payments.

III. Whether the Agency's approval of the State's reimbursement methodology precludes the Agency from adjusting for these excess payments.

IV. Whether the status of these providers as bankrupt or non-participating providers precludes adjustment.

The issues which are primarily procedural are discussed in the sections headed:

V. Whether the Agency had an adequate basis for its determination that the excess payments constitute an overpayment.

VI. Whether the Agency's disallowance letter was sufficient.

VII. Whether an earlier disallowance is res judicata with respect to part of

the disallowance here.

VIII. Whether the Agency should have instituted a compliance action here rather than a disallowance.

I. Whether the excess payments are overpayments under the statute, regardless of recovery.

A. Substantive basis for adjusting for these excess payments

The State argued that there is no substantive provision in the statute requiring the Secretary to recover an excess payment based on the State's determination of a final reimbursement rate.

We disagree. Section 1903(a) of the Act, the basic provision governing payment of FFP under Medicaid, requires the Secretary to pay each state with an approved plan ". . . an amount equal to the Federal medical assistance percentage of the total amount expended during the quarter as medical assistance under the State plan . . . ." (Emphasis sup-

plied). Section 1905(a) of the Act defines "medical assistance" as "payment of part or all of the cost" of covered services. Other provisions of the statute help define the limits of the allowable cost of such services.2/

2/ Section 1902(a)(30) requires that a State plan provide "methods and procedures relating to . . . the payment for, care and services available under the plan . . . and to assure that payments . . . are not in excess of reasonable charges consistent with efficiency, economy, and quality of care; . . . ." Effective July 1, 1976, a State plan had to provide for payment of nursing home services "on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary." Section 1902(a)(13)(E).

The State alleged that, since its State plan amendment implementing section 1902(a)(13)(E) was not effective until October 1, 1977, excess payments made prior to that date could not be disallowed. However, as indicated in footnote 1 above, the State has not shown any basis for distinguishing payments

(footnote continued)

Here the State provided for a method of payment which used an interim rate, subject to retroactive adjustment. As the State itself indicated, an interim rate is virtually certain to be incorrect since it is based on the adjusted cost of the preceding year. The final rate, on the other hand, is related to the provider's actual cost of providing services under the program. Since it is the final rate that corresponds to what the State has determined to be the proper charge for the services, and therefore, to the amount of the "medical assistance under the State plan," a substantive obligation

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(footnote continued)

determined by the State to be excess payments using other State plan methodologies, set out under 1902(a)(30), from the reasonable cost-related methodology used after October 1, 1977.

exists under section 1903 for the Secretary to allow FFP only in the amount of the final rate.

B. Requirement to adjust once overpayment determined

The State nevertheless argued that the Secretary, under "procedural" provisions of section 1903(d), may recover the federal share of the difference between the interim and final rates only to the extent that the State has already recovered the difference from the providers.

The statutory language does not support this position either, however. Section 1903(d)(1) requires the Secretary to "estimate" the amount that the State will be entitled to under section 1903(a) prior to the beginning of each quarter. Section 1903(d)(2) requires the Secretary to pay the amount so estimated "reduced

or increased to the extent of any overpayment or underpayment which the Secretary determines was made . . . for any prior quarter . . . ." The statute nowhere defines "overpayment." However, the Agency has consistently interpreted the term, together with the provision at section 1116(d) of the Act, to include amounts previously paid to a state, which have been determined to be unallowable. Section 1116(d) of the Act provides for reconsideration by the Secretary of a disallowance, and a final disallowance determination under this section has been interpreted as a basis for an adjustment on the quarterly statement of expenditures under section 1903(d)(2). See, 45 CFR 201.14 (1977).4/

4/ We also note that it is Agency practice in disallowance letters to direct a state to make an FFP adjustment if it does not contest the disallowance.

The State itself recognized that an "overpayment" within the meaning of section 1903(d)(2) has occurred if the State "has failed to comply with the substantive requirements found in other sections of Title XIX." State's December 10, 1981 submission, p. 25. As discussed above, the statute permits FFP only in payments properly made under the State plan. While here the State plan permitted provisional payment to a provider at the interim rate, it authorized final payment only at the final rate.

When the final rate is lower than the interim rate (at which the State claimed FFP), the Secretary properly may determine that an overpayment to the State exists and adjust payments to the State accordingly. Moreover, the overpayment adjustment is not limited under

section 1903(d)(2) to instances where the State has recovered the excess amount from the providers. The section simply authorizes an adjustment based on the Secretary's determination that an overpayment has occurred.

C. Effect of section 1903(d)(3)

The State argued, however, that section 1903(d)(2) should be interpreted more narrowly based on the terms of section 1903(d)(3) and its legislative history. Section 1903(d)(3) requires the Secretary to consider as an "overpayment":

> The pro rata share to which the United States is equitably entitled . . . of the net amount recovered during any quarter by the State . . . with respect to medical assistance furnished under the State plan . . . .

The State argued that this section modifies the conditions for adjusting

overpayments under section 1903 (d)(2) by preventing adjustment until the State has actually recovered the overpayment. The Agency argued persuasively against this interpretation, and we agree for the following reasons:

- Section 1903(d)(3) does not by its terms relate back to all overpayments contemplated by section 1903 (d)(2).

- Since 1903(d)(3) refers to amounts recovered with respect to "medical assistance furnished under the State plan," it reasonably may be viewed as referring to State payments which are allowable "medical assistance" costs. Such instances would include overpayments arising from third party reimbursements as contemplated by section 1902(a)(25); see, also, the second sentence of section 1903(d)(2). Excessive payments to the State arising from an overestimate of provider rates, on the other hand, would not qualify as "medical assistance."

- The extensive legislative history cited by the State primarily supports the Agency's position that section 1903(d)(3) was designed

to authorize the Secretary to adjust in situations such as third party reimbursements where a question might have existed as to the State's liability to repay the federal share or the Agency's authority to recoup the share by an offset to future claims. This interpretation gives full effect to all of the statutory provisions at issue. If Congress had wanted to ensure the State's outcome, it could have done so with a simple amendment to section 1903(d)(2) to limit adjustment of overpayments to situations where a state had already recovered funds.

- Neither the Agency nor the courts have ever interpreted section 1903 (d)(3) so as to prevent adjustment of an overpayment under section 1903(d)(2), irrespective of state recovery from a provider. This applies to overpayments resulting not only from excessive payments, but also from payments made for services or care not covered by the program or for persons ineligible for such care or services. HCFA pointed to sixteen years of consistent application of the statute in its regulations and fiscal procedures and argued that longstanding interpretations of law, which were not disturbed by Congress when it amended the law, are presumed to have the approval of Congress and to be consistent

with Congressional intent.[4]

When the relevant statutory provisions are read as a whole, we believe that the Secretary has a substantive obligation to base Medicaid payments to the State on the State's final rate and need not delay an adjustment necessitated by an overestimate merely because the State has not recovered the excess payments from the provider.[5]

4/ The State did not dispute the Agency's claim that it had this long-standing interpretation and practice. In fact, the record shows that the State had notice of this interpretation as [sic] least as of February 22, 1977. State's December 24, 1980 brief, Ex. D-1.

5/ In our decision in California Department of Health Services, Decision No. 244, December 31, 1981, we discussed the effect of section 1903(d)(3) on the issue of whether a difference between an interim and final rate of reimbursement can be considered an overpayment prior

(footnote continued)

II. Whether the Agency's regulations are valid and require adjustment for these excess payments.

The Agency cited the following provision in support of its position that the State should pay back the federal share of excess payments to providers, regardless of recovery by the State:

> The [State] agency must account for overpayments found in audits on the quarterly statement of expenditures no later than the second quarter following the quarter in which the overpayment was found. (See 45 CFR 201.66 for accounting for overpayments.)
>
> (42 CFR 447.296, formerly codified at 45 CFR 250.30(a)(3)(ii)(G))

(footnote continued)

to recovery and reached the same conclusion. However, we have not here relied solely on our analysis in Decision No. 244 but have reexamined the issue in the context of this case and Massachusetts' system of reimbursement.

This provision appears in the context of the regulations establishing requirements for reimbursement of Medicaid providers, including that the State must audit providers' cost reports to ensure that only allowable provider costs are being considered in the rate-setting process.[6/] We agree with HCFA that

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6/ The State argued that 42 CFR 447.296 was not adopted until July 6, 1976 and that, therefore, excess payments made prior to that date could not be disallowed. The State is correct that no regulation existed prior to July 1, 1976 specifying when the State must account for excess payments determined as a result of cost settlement audits. However, the State is not correct concerning the absence of a substantive basis for the disallowance prior to that date. Under the statute, these costs are unallowable and, without the regulation, the Secretary may adjust for the federal share of such excess payments as soon as he determines that it constitutes an overpayment to the State.

this provision supports the interpretation that an excess payment to a provider, found as a result of a cost settlement process, may constitute an overpayment to the State to be adjusted, regardless of whether the State has recovered the amount from the provider. The term "overpayments" in this regulation clearly encompasses a differential between an interim and final rate determined by a state's rate-setting process. The time specified for adjustment in the provision is not contingent on recovery.

The State challenged the regulation, however, on two grounds: That it was invalid as not reasonably related to the purposes of the statute and that, in any event, the Agency had not interpreted the regulation correctly. We discuss these two issues below.

A. Validity of regulation

The State argued that a regulation having the meaning attributed to 42 CFR 447.296 by HCFA would be invalid as plainly inconsistent with the purpose of Title XIX. The State suggested that the effect of the regulation is to impose strict liability on a state for losses sustained under its reimbursement system and that the State, as a partner in the Medicaid program, should not be expected to bear more than a fair share of unavoidable losses. In this respect the State pointed to the limited liability in certain instances of fiscal intermediaries and carriers under the Medicare program. Finally, the State argued that the regulation serves as a disincentive for the State to adopt a retroactive reimbursement system.

We are not persuaded by the State's arguments. With respect to the State's first point, the adjustment for overpayments pursuant to the regulation here is fully consistent with the statute. As we have discussed at length, the statute does not make adjustment contingent on State recovery. The State's position conflicts with statutory intent by permitting the State to retain funds not covered by the program. Moreover, although the Department considered requiring an immediate adjustment for overpayments found in audits, it instead adopted a more liberal rule incorporating a grace period of two quarters. 41 Fed. Reg. 27304 (1976). The State has an automatic adjustment procedure whereby it recovers most of its overpayments stemming from rate changes within this time frame. The absence of exceptions

for bankrupt or non-participating providers in the regulation might be explained in part because this extended time frame was provided for adjusting overpayments generally.

Furthermore, a uniform rule may serve important program purposes by encouraging the State to monitor more closely the financial viability of its providers and to develop systems to recover overpayments before a provider drops out of the program or becomes bankrupt. As the Agency pointed out, the policy may also encourage states to be more precise and conservative in setting interim rates. While the lack of exceptions may indeed serve as a disincentive for the State in selecting this payment option, the option as a whole may have fiscal advantages that counterbalance this factor. Finally, the comparison with the Medicare

program is not convincing here. The State has the primary responsibility under Medicaid for administering its program, and as a consequence might reasonably be expected to assume responsibility for excessive payments to providers, including those where collection has been delayed or even barred.

B. Interpretation of the regulation

As an alternative argument, the State challenged the Agency interpretation of the regulation, arguing that the phrase "account for" should not be interpreted as imposing strict liability on the State, but rather as merely imposing a duty on the State to use reasonable care in promulgating the interim rate and in endeavoring to recover overpayments from providers resulting from rate decreases.

The plain terms of the regulation, however, require the State to account for the overpayments on its quarterly statement of expenditures.[7/] This is reinforced by the preamble to the origi-

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7/ The quarterly statement of expenditures is described in Department regulations as follows:

> This is an accounting statement of the disposition of Federal funds granted for past periods and provides the basis for making the adjustments necessary when the State's estimate for any prior quarter was greater or less than the amount the State actually expended in that quarter. The statement of expenditures also shows the share of the Federal Government in any recoupment, from whatever source, of expenditures claimed in any prior period, and also in expenditures not properly subject to Federal financial participation which are acknowledged by the State agency or have been revealed in the course of an audit.
>
> (45 CFR 201.5(a)(3))

nal provision which specifies that such overpayments must be "accounted for on the SRS OA-41 [now HCFA-64] report." 41 Fed. Reg. 27304, July 1, 1976. Such a report is intended for use in making accounting adjustments, not as a means for the State to report on whether it is fulfilling a duty of using "reasonable care."

Moreover, section 447.296 refers to 45 CFR 201.66 with respect to accounting for overpayments. Section 201.66 deals with repayment of federal funds by a state, permitting a state to make such repayment in installments where certain conditions are met.

The cases cited by the State (State's December 10, 1981 submission, p. 10) do not support the State's interpretation, for the simple reason that they concerned

Department of Agriculture regulations in a totally different context and, therefore, are not relevant to the interpretation of section 447.296.

III. Whether the Agency's approval of the State's reimbursement methodology precludes the Agency from adjusting for these excess payments.

A. Approval of the rate-setting method

The State argued that, since its rate-setting methodology was in accordance with the statute and was approved by the Secretary, the differential between the interim and final rates of reimbursement should not be considered an overpayment. According to the State, while the interim rate is based on the State's best guess as to what the provider's actual costs will be, the interim rate is "virtually certain to be incorrect." (State's December 10, 1981 sub-

mission, p. 11). The State maintained,

> The certainty of error in the interim rate was known to the Secretary when the retrospective rate system was approved. By approving the use of a reimbursement methodology which was virtually certain to result, in some cases, in overpayments to providers, together with the provision that the State would seek to collect those overpayments, the Secretary agreed to share the risk that the overpayments might not be recovered by the State.
>
> (State's December 10, 1981 submission, p. 13)

We disagree. While Congress gave the states some leeway in using their own methodologies to determine rates of reimbursement for Medicaid costs, including the possibility of using a retrospective system, the State has pointed to nothing in the statute or its legislative history to indicate that Congress intended to provide FFP in any payments which exceeded the final rate ultimately determined by the State to be

the proper one.[8/]

The purpose of the 1972 amendments on which the State relied in part was to give the states maximum possible flexibility to develop methodologies for cost-finding and reasonable cost-related reimbursement, within the limits set by the Secretary. See, 41 Fed. Reg. 27300, July 1, 1976. Flexibility in the manner of establishing allowable costs cannot be translated, however, into an authorization to pay FFP in costs beyond those

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8/ While the Agency does pay the State for claims for FFP for payments to providers based on an interim rate which is merely an estimate, this payment is only tentative. Payment of the estimate is consistent with the general Title XIX scheme of advance payment to states based on estimates. Section 1903 of the Act. Willingness to pay based on an estimate cannot be considered tantamount to willingness to continue to bear the cost differential between an estimated and final payment, however. As with other advances based on estimates, we think the Agency properly sought an adjustment here.

established by the State as being allowable. The State was permitted to use its own methodology here to establish a reimbursement rate. As the State itself recognized, however, the final rate, once established, represents the amount properly payable under Medicaid on a reasonable cost related basis.

B. Approval of the collection process

The State also argued that its regulations establishing a system for collecting overpayments were expressly approved by the Agency's predecessor, the Social and Rehabilitation Service. According to the State,

> HCFA is therefore estopped from disallowing federal financial participation for amounts which remain uncollected as a result of the [State] Department's adherence to those regulations.
>
> (State's April 28, 1980 submission, p. 4)

The State attempted to read too much into the Agency's approval of the State's collection regulations. By its approval, the Agency merely permitted the State to use a particular method of offsetting past overpayments against future payments due to the providers. As the State acknowledged here, the State system for collection has been interfered with in the case of bankrupt and non-participating providers. (State's December 24, 1980 brief, p. 33). The Agency could reasonably approve use of the State's collection system for other providers and wait for recovery by use of this system for adjustment of FFP, while requiring adjustment without recovery where the State's method of collection has broken down.

Thus, the State has shown nothing in the Agency approval of the State method-

ology for determining the rate, or for collecting overpayments, which could reasonably be relied on as a basis for not adjusting for improper payments to bankrupt or non-participating providers prior to the State's recovery from the providers. We also note that the Agency approval here must be considered in the context of the entire State plan, which defined allowable costs of the program, and which, after November 22, 1976, incorporated the regulatory provision specifying adjustment for overpayments found as a result of an audit no later than the second quarter following the quarter in which the overpayments were found. The State's argument that this plan provision was merely a check on a preprinted State plan amendment form used by the Agency lacks merit. Many State plan provisions are incorporated in this

manner and are no less a part of the State plan than any other provision.

IV. Whether the status of these providers as bankrupt or non-participating providers precludes adjustment.

A. Providers in bankruptcy proceedings

The State argued that it is not liable for that part of the disallowance attributable to overpayments made to providers which subsequently went bankrupt. The State contended that any overpayments made to providers which are in proceedings before a bankruptcy court have been discharged by the Bankruptcy Act and are therefore uncollectable by the State.

In response the Agency argued that while bankruptcy proceedings may discharge a provider's debts to the State, they do not discharge the State's obligations to the Agency. According to the

Agency, "There is no provision in this country's bankruptcy laws which relieve [sic] one debtor from its obligations when it is not bankrupt simply because one of its own debtors has been discharged in bankruptcy." (Agency's October 22, 1981 submission, p. 10). In support of its position, the Agency referred to a bankruptcy proceeding, In re Idak, before the United States Bankruptcy Court, District of Massachusetts. In that proceeding, involving several nursing homes, the State sought to restrain the Secretary of HHS from reducing the State's entitlement to FFP for payments which the State made to the debtors under the Medicaid program. HHS, having reimbursed the State for a percentage of the total Medicaid payments made to the debtor nursing homes, asserted a right

to recoup the full federal portion of any overpayments made by the State to the nursing homes. The State argued that HHS was not entitled to the full share of such overpayments to the debtors. The State also sought a determination from the court that, to the extent any part of its claim against the debtors for Medicaid overpayments was discharged, the State obligation to HHS resulting from such overpayments would likewise be discharged.

In a May 21, 1981 Order Partially Dismissing Proceeding, the court ruled that it lacked jurisdiction to grant the relief requested by the State against HHS. The court declared:

> The dispute between the [State] and the United States is in essence simply between an alleged creditor of the debtors

> and a third-party which has no impact on the debtors or on the Chapter XI [bankruptcy] proceeding.
>
> (p. 3)

While it is true that Congress devised the Medicaid program as a joint federal-state endeavor, Congress gave each state participating in the Medicaid program the authority to administer the program within the state. The matter before us concerns the State's administration of its Medicaid program. It is the State's responsibility to expeditiously recover any overpayments that may have been made. The Agency has no direct role in the recovery of such overpayments. The Agency is not unreasonable, therefore, in requiring the State alone to bear the burden which may result from delays in the collection of overpayments from providers, notwithstanding the fact that the providers might at some

time declare bankruptcy.

We conclude, therefore, that the Agency is entitled to recover from the State the overpayments made even to those providers which may have had their obligation to the State discharged in bankruptcy proceedings.

B. Providers no longer participating in the Medicaid program

Nearly half of the disallowance represents overpayments to providers no longer participating in the Medicaid program. The State claimed that there were several mistakes in the disallowance letter as to what amount was due from specific providers: 21 of the providers had repaid the overpayments to the State which then remitted the federal share to the Agency; the State had sued six of the providers and had obtained at least a partial recovery; and numerous

discrepancies in repayment obligations existed between the amounts shown on the disallowance letter and the State's preliminary analysis. (State's January 8, 1982 submission, pp. 4-5).

The State has not provided the Board with any legal arguments, however, as to why the Agency should be required to wait for repayment once there was a determination that overpayments had occurred. The State's method of collecting the amounts owed by a provider through offset against future payments was a means of recovering overpayments from providers who remained in the Medicaid program. Recovery from providers who dropped out of the Medicaid program may be more difficult as it requires a further action by the State, such as suing for recovery, but that does not excuse the State from refunding the federal share to the Agency. The Agency,

through 42 CFR 447.296, gives the State adequate time to recover these overpayments. It is the State's responsibility to recover these costs and it must bear the consequences for failing to do so.

We find, therefore, that the Agency is entitled to require the State to repay the federal share of overpayments made to providers no longer participating in the Medicaid program. We leave it to the State and Agency, however, to adjust the disallowance if the State has repaid some of the amounts.

V. Whether the Agency had an adequate basis for its determination that the excess payments constitute an overpayment.

The State took the position with respect to the meaning of "overpayment" in 1903(d)(2) that --

> the retrospective rate decrease is simply not "an overpayment . . . which the Secretary determines was made . . . to such State . . ." The overpayment arose out of a determination made by the Rate Setting Commission, not the Secretary, after the Commission reviewed the provider's cost reports and found that the Interim Rate was too high. The overpayment resulting from that determination was made, not to the State, but to the providers.
>
> (State's December 24, 1980 brief, Ex. A-7, p. 6)

We agree with the State that the RSC's determination of a final rate, lower than an interim rate, is not a determination by the Secretary that an overpayment has been made to the State. Moreover, an amount which the State has determined to be an excess payment by the State to a provider is not always an overpayment for federal purposes (e.g., if the State never claimed FFP in the original payment). However, what we are dealing with here is the Agency's deter-

mination that the State, having been paid FFP at an interim rate, which the RSC has now determined to be too high under the State plan, has received an overpayment of Title XIX FFP to the extent of the difference in the two rates. This is a determination that the costs are unallowable for FFP and requires adjustment unless reversed by the Board upon reconsideration.

In examining an Agency disallowance determination, the Board has required that such a determination, to be upheld, must be factually and legally supported by the record. Where the Agency determination is based on State audits or records, the sufficiency of the Agency determination may depend on the reliability of those State audits or records.

The State questioned the basis for the Agency determination in general, as well as pointing to three specific alleged defects:

- The State contended that the disallowance was insufficient in that HCFA had failed to point to any substantive provision in the statute which supported the disallowance, since section 1903 merely deals with the procedure for adjustment once an overpayment determination has been made.

- The State argued that the Agency should not have used the State's Account Receivable Ledger Cards because those records included adjustments which resulted in changes from one interim rate to another or from an interim rate to a final rate which was still subject to adjustment on appeal.

- The State challenged the accuracy of the agency's figures, stating that its analysis showed that the amounts disallowed were wrong.

Based on our examination of the record, however, we have determined that there is an adequate basis for the disallowance, both factually and legally. The

Agency determination here was based on the State's own records, resulting from a process which the State itself has described as follows:

> When a retroactive rate decrease takes effect, the Retroactive Nursing Home Unit calculates the amount attributable to the decrease and enters that amount on separate records, one for each provider, known as the Account Receivable Ledger Cards. At any given time, the sum of the amounts shown on a provider's Account Receivable Ledger Card represents the total amount which the Retroactive Nursing Home Unit will seek to recover from the provider.
>
> (State's December 24, 1980 brief, p. 31)

The Agency auditors used these Account Receivable Ledger Cards in two specified categories (bankrupt providers and providers no longer participating in the program), identifying the particular providers and using the amounts shown on the cards. The amounts clearly related to rates which had been determined, in ac-

cordance with the methodology set out in the State plan, to be in excess of the rates payable under the State plan for the services provided. While the Agency did not initially cite the substantive provisions rendering these costs unallowable, they were implied from the context and clarified in the Agency's response to the appeal.

Although the State questioned the Agency's reliance on the Account Receivable Ledger Cards, the State has not provided any evidence which would convince us that that reliance was misplaced. The State's proposed corrections to the Agency's figures for certain providers are based on recoveries made by the State from the providers subsequent to the time the Agency examined the records. State's January 8, 1982 submission. As the Agency pointed out, however, the fact that

records may be subject to later adjustment does not render them unreliable at any particular point in time. So long as the Agency makes appropriate revisions to the disallowance amounts, as it has indicated a willingness to do here, the State is not prejudiced by use of such records. Moreover, the Account Receivable figures were derived from State audits which the State was required to perform in accordance with generally accepted accounting principles.

The State has also failed to convince us that any excess payment amount reflected in these records derived from a merely tentative rate determination on the part of the State, which might be revised upon subsequent review, or that the records improperly included amounts derived from interim to interim rate decreases. Although the State purported to have evi-

dence that some of the rate decreases here were still under appeal, the State did not submit such evidence as it stated it would. The summary analysis of State documentation (submitted by the State to the Agency at a late stage in the Board's proceedings) contains a column for "Appeals" in which there are no entries. Moreover, we think it unlikely that there are any pending administrative provider appeals concerning the rate decreases in question here given the lapse of time since the RSC rate determinations.

With respect to the question of whether interim to interim rate adjustments were improperly included, we are also unpersuaded by the State's argument. The Agency reviewers described these overpayments as relating to time periods for which the RSC had determined final

rates, and the State has presented nothing to contradict this. It is reasonable to assume that the Account Receivable figures represented net overpayments, taking into account proper adjustments for all interim and final rates, given the State's system of records kept by the RNHU.

Thus, there is no reason for us to believe that the amounts in question did not represent the State's final determinations as to the amounts owed by these providers.[9/]

9/ We also note that the State itself considered any rate filed by the RSC with the Secretary of State to be a sufficient basis for recovery from the provider. See, State's December 24, 1980 brief, p. 31.

VI. Whether the Agency's disallowance letter was sufficient.

The State argued that the Agency's notification of disallowance did not meet the requirements of 45 CFR 201.14(b), in that it failed to set forth either the dates or time periods on which FFP is alleged to have been claimed or the dates on which it was paid. The State claimed that it was prejudiced throughout the proceedings before the Board by the Agency's failure to supply further information on which the disallowance was based. The State cited the Agency's failure to attribute the disallowed amounts to particular quarters as one significant example of the notification's deficiency. The State claimed that various communications from the Agency made it impossible to ascertain the exact date of the review and the periods covered by the disallow-

ance. The State further objected to the Agency's use of a 50% rate for FFP in the disallowance letter as the standard throughout the whole time period covered by the disallowance since the federal medical assistance percentage (FMAP) changed several times during the time period in question. The State said that the 50% rate ceased being effective on October 1, 1977 when the rate was changed to 51.62%. The State contended that the notification of disallowance thus did not adequately set forth a claim for a disallowance and that the Board should therefore dismiss the disallowance.

The State is mistaken in its initial argument that the notification of disallowance had to comply with the requirements of 45 CFR 201.14. The March 6, 1978 transfer to the Board of jurisdiction over reconsideration of disallow-

ances stated that all appeals of disallowances after that date would be governed by the Board procedures set forth at 45 CFR Part 16. The Board rules in effect when this dispute arose state a notification must "set forth the reason for the determination in sufficient detail to enable the grantee to respond . . . ." 45 CFR 16.5(b)(1) (1979). The notification of disallowance issued by the Agency identified the regulations and statutory provisions on which the disallowance was based. The notification also contained a breakdown of the disallowance for each provider, showing the provider's identification number. We find that this was sufficient to meet the requirements of 45 CFR 16.5(b)(1) and provided the State with adequate information to respond to the disallowance. We also note, as the Agency has pointed

out, that all the information on which the disallowance was formulated was gathered from the State's own records, particularly the Account Receivable Ledger Cards.

As to the State's assertion that the Agency improperly used only the 50% FMAP to calculate the disallowance for the entire period in question, we agree with the Agency that the use of this one rate actually benefited the State in the calculation of any possible disallowance. For example, the Agency could have disallowed any FFP claimed after October 1, 1977 at the 51.62% FMAP rate. It is within the Agency's discretion not to disallow at the fullest possible amount if it is administratively convenient to apply one consistent rate. Thus we find that the State was not prejudiced by the Agency's use of the 50% FMAP.

VII. Whether an earlier disallowance is res judicata with respect to part of the disallowance here.

In its latest submission to the Board, the State raised as an additional ground for reversing part of the disallowance before us --

> That for the two year period 1971 and 1972, HCFA has already disallowed the federal share of rate decreases as set forth in Exhibit D of the State's December 24, 1980 submission. That disallowance is res judicata as to the present disallowance; . . .
>
> (State's January 8, 1982 submission, p. 3)10/

10/ The State requested an additional extension of time to brief this and other issues, arguing that the State became aware of the facts underlying these issues only after it had completed its more detailed analysis of the records. The requested extension was denied for a number of reasons, including that the State had had the duty to be aware of sufficient facts to raise the issues prior to that submission. Board's February 12, 1981 Ruling, p. 2.

(footnote continued)

Exhibit D, to which the State refers, is a letter from the Acting Administrator of the Social and Rehabilitation Service (SRS) to the State, upholding a disallowance of FFP in amounts found to represent unrecovered payments to providers in excess of the allowable reimbursement rates. This decision, dated February 22, 1977, was the result of a reconsideration by the Acting Administrator under 45 CFR 201.14, of a disallowance by the Regional Commissioner, SRS. The Acting Administrator recognized that, subsequent to the audit which identified the excess payments, the State had instituted its collection system and had recovered some of the excess payments. Therefore, the

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(footnote continued)

However, as we indicated in our ruling denying the requested extension, we have considered all issues raised by the State, based on the record before us.

Acting Administrator requested the Regional Commissioner to determine the amount to be recovered and to deduct the proper amount from the State's grant award. (p. 3). The decision noted that, as of March 23, 1976, a balance of $202,371 in FFP had not yet been recovered and credited to the federal government.

We agree with the State that this decision would be res judicata with respect to the issue of whether any excess payments covered by the Acting Administrator's decision were allowable. The Acting Administrator determined, however, that they were not allowable. The State as part of its argument on another point appeared to rely on a statement by the Regional Commissioner, made during the reconsideration proceedings for this earlier disallowance, to the effect that,

since the State had instituted collection procedures, the disallowance should be withdrawn. (State's December 24, 1980 brief, Ex. D-11). The record shows, however, that the Acting Administrator did not adopt this position, but upheld the disallowance.

The critical issue, therefore, is whether the State has repaid the federal share of the identified unallowable payments, in accordance with the Acting Administrator's decision. If so, and if the State could show that some of the amounts here duplicated those amounts for which there has already been an adjustment of FFP, the disallowance here should be reduced accordingly. We consider this, therefore, part of the question of the correct quantum of the disallowance. There is no reason to assume that the Agency will not make the proper

adjustment if the State can show that there was, in fact, some duplication of the amounts covered by the Acting Administrator's decision and that the State made the corresponding adjustment of FFP. Since the State has not yet made such a showing, we do not consider this a reason for overturning any part of the disallowance. However, the Agency should consider any documentation submitted by the State on this point, and, if the parties cannot agree on this matter, the State may further appeal it to the Board.

VIII. Whether the Agency should have instituted a compliance action here rather than a disallowance.

The State argued that the dispute raised by the Agency's determination was not a disallowance, but rather a question of program compliance required to be resolved pursuant to section 1904 of

the Act. The State contended that the Board was therefore not the appropriate forum to review this determination as, while the Board has jurisdiction over disallowances arising under section 1116(d), the Board does not have jurisdiction over section 1904 compliance matters.

Both parties submitted extensive briefing on this subject. The Board Chair considered the merits of these arguments when he issued his September 18, 1981 Ruling on Jurisdiction. That Ruling, while declaring that the distinctions between compliance and disallowance issues are often not clear-cut and that the same set of facts could arguably call for either of the procedures, nevertheless held that the facts presented in this case could reasonably be interpreted as a disallowance. The Chair found that

there was no determination that the State's rate methodology to providers involved a substantial noncompliance with the provisions of the Social Security Act requiring a hearing under section 1904. Rather, the Chair found that the Agency had determined that specific payments to certain providers were unallowable costs and that this determination thus met the criteria for a "disallowance."

Recently, in New Jersey Department of Human Services, Decision No. 259, February 25, 1982, the Board examined the compliance/disallowance question in detail, and we refer the parties to that Decision for an extended discussion of the issues. The Board there reviewed the statutory distinctions between these Agency procedures and the court treatment of the issue, including several recent

decisions by the Third Circuit Court of Appeals, in which the State of New Jersey sought appellate review of several Board decisions. The Third Circuit stated that a court of appeals, in determining whether it is an appropriate forum for review of an action by the HHS Secretary, should not be bound by the label the Secretary puts on his action, but rather should "conduct an independent evaluation of the underlying substance of the dispute." State of New Jersey v. Department of Health and Human Services, Nos. 80-2809, 81-1400, 81-1445, 81-2147, and 81-2240 3rd Cir. Dec. 28, 1981, slip op. at 18). In light of the Board's New Jersey decision, we have re-examined what is "the underlying substance of the dispute" here and continue to believe that the Agency could within its discretion take a "disallowance," thereby making

the Board the appropriate forum for review of the Agency's action.

In order for there to be a compliance question, there must be a finding by the Secretary that a state has failed to comply substantially with a provision of its State plan. Even though the State was not meeting one of the requirements of its state plan here, we conclude that the Secretary could reasonably have found that there was no question of substantial noncompliance by the State. The Agency's determination covered only a relatively small segment of the State's whole rate methodology and reimbursement system, namely the recovery of excess payments from those providers who had ceased participating in the Medicaid program or had gone bankrupt. Furthermore, there was no finding that the ultimate program beneficiaries, the Medicaid recipients,

were in any way affected by the questioned State practice.

Further, we do not believe that the State has been prejudiced here by Board review of the Agency's action because the State has been given a full opportunity to present its legal arguments. With respect to the adequacy of the Board's procedures even in a compliance context, the court in New Jersey v. Department of Health and Human Services, No. 80-2438 (3rd Cir. Feb. 5, 1982), stated:

> We find nothing in the Act or its legislative history that precludes our treating the Grant Appeals Board's action on behalf of the Secretary in this dispute as a "final determination" rendered after an "opportunity for hearing" sufficient to satisfy the requirements of [section 1904] and thereby vest jurisdiction in this Court under [section 1116(a)(3)]. (Slip op. at 18 n. 13).

Although the Board did not provide the State with an evidentiary hearing in this case, we believe that the State had sufficient opportunity to present its legal arguments on the issues. While the State did request a hearing to clarify the dates and rates involved here, we believe that any such information concerns only the question of the disallowance amount which we have left to the parties to resolve and not the underlying substantive legal issues. The quantum of unallowable costs would not in any event have been at issue in a compliance proceeding.

Conclusion

For the reasons stated above, we sustain the disallowance. Since the State may have already paid back the federal share of some of the excess payments,

however, the Agency should provide a reasonable opportunity to the State to provide documentation of any such repayment. After reviewing any documentation submitted by the State, the Agency should recalculate the amount of the disallowance, notifying the State in writing if the Agency disputes the State's figures concerning how much has been repaid. The State may then appeal this determination to the Board solely on the issue of how much has been repaid. Nothing in this decision precludes the Agency from adjusting for the federal share of any excess payments not claimed by the State to have been repaid, while the Agency is reviewing the documentation.

Norval D. (John) Settle

Alexander G. Teitz

Donald F. Garrett

Presiding Board Member

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

No. 84-1197

THE COMMONWEALTH OF MASSACHUSETTS
BY ITS DEPARTMENT OF PUBLIC WELFARE,
Plaintiff, Appellee,

v.

SECRETARY OF HEALTH AND
HUMAN SERVICES, ET AL.,
Defendants, Appellants.

JUDGMENT

Entered: November 28, 1984

This cause came on to be heard on appeal from the United States District Court for the District of Massachusetts, and was argued by counsel.

Upon consideration whereof, It is now here ordered, adjudged and decreed as follows: The judgment of the District Court is reversed. No costs.

By the Court:

FRANCIS P. SCIGLIANO, Clerk

Text of Statutes Involved

Section 1903 of the Social Security Act, 42 U.S.C. § 1396b, provides in pertinent part as follows:

(a) Computation of amount

From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this subchapter, for each quarter, beginning with the quarter commencing January 1, 1966 --

(1) an amount equal to the Federal medical assistance percentage . . . of the total amount expended during such quarter as medical assistance under the State plan . . .

* * *

(d) Estimates of State entitlement; installments; adjustments; overpayment; obligated appropriations; disputed claims.

(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) of this section for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such

other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection. Expenditures for which payments were made to the State under subsection (a) of this section shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with

section 1396a(a)(25) of this title.

(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

Section 1905 of the Social Security Act, 42 U.S.C. § 1396d, provides in pertinent part as follows:

§ 1396d. Definitions

For purposes of this subchapter --

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and ser-

vices (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals . . . who are --

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

(ii) relatives specified in section 606(b)(1) of this title with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of subchapter IV of this chapter,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter.

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under subchapter I, X, XIV, or XVI of this chapter,

(vii) blind or disabled as defined in section 1382c of this title, with respect to States not eligible to participate in the State plan program established under sub-chapter XVI of this chapter, or

(viii) pregnant women.

but whose income and resources are

insufficient to meet all of such cost --

* * *

(4)(A) skilled nursing facility services . . . for individuals of 21 years of age or older . . .,

* * *

(15) intermediate care facility services . . . for individuals who are determined in accordance with section 1396a(a)(31)(A) of this title, to be in need of such care . . . .

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No. 84-1363

In the Supreme Court of the United States

OCTOBER TERM, 1984

COMMONWEALTH OF MASSACHUSETTS, PETITIONER

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

MEMORANDUM FOR THE RESPONDENTS IN OPPOSITION

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

MEMORANDUM FOR THE RESPONDENTS IN OPPOSITION

Petitioner challenges the court of appeals' ruling that the federal government is entitled to recoup a portion of advance Medicaid payments made to a state when those payments exceed the amount eventually determined to be due the state, but the state itself has been unable to obtain reimbursement from the Medicaid providers to whom it advanced excess funds for the provision of Medicaid services. Petitioner's argument is based on what it calls the "clear statement rule" of *Pennhurst State School & Hospital*

v. *Halderman*, 451 U.S. 1 (1981), under which, petitioner contends, any ambiguous term in a statute that authorizes federal grants to states must be construed in favor of the states.

1. To participate in the Medicaid program, a state must develop a Medicaid plan that is consistent with the requirements of the statute and the regulations promulgated thereunder. If the Secretary of Health and Human Services approves the state plan, she will provide the state with a grant in partial reimbursement of the amounts paid out under the plan to providers of medical assistance. 42 U.S.C. 1396a. Federal grants are paid in advance of each quarter, based on an estimate of the state's costs. 42 U.S.C. 1396b (d). Federal payments to a state are "reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter" (42 U.S.C. 1396b(d)(2)).

Petitioner uses a similar system to pay Medicaid providers; it makes interim payments for the upcoming year at a rate based on estimates of the provider's costs, and then sets a final rate after the end of the year based on an audit of the provider's actual costs. If the final rate is lower than the interim rate already paid, petitioner collects the excess amount by adjusting the provider's interim rates for later years. Pet. App. 4-6.

When the Health Care Financing Administration (HCFA) of the Department of Health and Human Services audited petitioner's ledgers for the period from April to November 1979, it discovered that petitioner had made excess interim payments to a number of Medicaid providers and that it had never recovered from the providers the difference between the

interim payments and the final rates established by the state (Pet. App. 11-12). Accordingly, HHS reduced petitioner's next quarterly grant by the amount of these excess payments, concluding that they were "overpayment[s]" to the State within the meaning of Section 1396b(d)(2) (Pet. App. 8, 12). Petitioner objected, contending that an excess payment that it makes to a provider is not an "overpayment" unless and until it recovers the amount of that excess payment from the provider (*id.* at 9). While conceding that it must reimburse the Secretary for all excess payments actually recovered, petitioner took the view that there could be no "overpayments" in this case because the excess payments were made to providers that subsequently filed for bankruptcy or were otherwise unable or unwilling to reimburse the State (*id.* at 7, 9-10).

2. The Departmental Grant Appeals Board upheld HCFA's determination that the Secretary was entitled to reimbursement (Pet. App. 57-122). Petitioner then filed this action in the United States District Court for the District of Massachusetts, and the district court reversed the agency's decision (*id.* at 41-56). The district court found that the statute was ambiguous and determined that the ambiguity could be resolved only by examining the policies underlying the Act (*id.* at 49-53). When it turned to those policies, the district court concluded that the Secretary and the State ought to share the loss of unrecoverable Medicaid payments because Medicaid is a federal-state partnership (*id.* at 53-55).

The court of appeals reversed (Pet. App. 1-38). The court agreed with the district court that the statute was ambiguous, finding the "statutory arguments presented on both sides equally balanced" (*id.* at 31-

32). In these circumstances, the court resolved the issue in the Secretary's favor based on considerations of legislative and administrative policy (*id.* at 32). The court determined that Congress would have intended courts to give the Secretary's construction "significant weight" (*id.* at 35), particularly because Section 1396b(d)(2) "commands that federal grants be reduced 'to the extent of any overpayment . . . which *the Secretary determines* was made'" (Pet. App. 34 (emphasis in original)). The court also reasoned that "the weight of policy seems to us to fall on the side of the Secretary's interpretation" because petitioner "is clearly the party best able to minimize the risks resulting from dealing with insolvent providers" (*id.* at 35-36). Accordingly, placing the risk of loss on the state "increase[s] its incentive to take care, whereas the Secretary remains powerless to reduce the risks no matter what the costs imposed on her" (*id.* at 36-37).

In ruling for the Secretary, the court of appeals rejected petitioner's reliance on *Pennhurst State School & Hospital* v. *Halderman*, 451 U.S. 1 (1978), reasoning that "[w]e do not believe that *Pennhurst* requires that every arguably ambiguous provision conditioning the receipt of federal funds by a state be construed in the state's favor" (Pet. App. 29). In an analysis that foreshadowed this Court's decision in *Bennett* v. *Kentucky Dep't of Education*, No. 83-1798 (Mar. 19, 1985), the court of appeals explained its rationale as follows (Pet. App. 29-30):

> *Pennhurst* found the imposition of new conditions on the receipt of federal funds repugnant to the notion that by accepting the funds the state had thereby entered into a contract with the federal government and was entitled to have

> its bargain enforced as written. *Pennhurst*, 451 U.S. at 17. The present case involves not the imposition of a new condition on the state but the interpretation of the provisions governing the remedies available to the federal government. No principle of contract law requires us to construe such a provision consistently against a federal government obligee.

3. Virtually the only argument presented by petitioner is based on a reading of *Pennhurst* that this Court rejected in *Bennett* v. *Kentucky Dep't of Education*.[1] Accordingly, further review is unwarranted.

a. In *Pennhurst*, this Court held that grants to the states are "in the nature of a contract," the terms and conditions of which the states must "voluntarily and knowingly accept[]" (451 U.S. at 17). From this premise, the Court articulated the "clear statement rule" on which petitioner relies (Pet. 22 n.14). The Court held (451 U.S. at 17 (footnote omitted)):

> There can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it. Accordingly, if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously.

As noted, the court of appeals found *Pennhurst* distinguishable from the instant case. Nevertheless, petitioner contends that *Pennhurst*'s "clear statement rule" is applicable "to the interpretation of existing

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[1] The petition in this case was filed before the decision in *Bennett* v. *Kentucky Dep't of Education* was announced, and petitioner relies heavily not only on *Pennhurst* but also on the Sixth Circuit's decision that was reversed by this Court in *Kentucky* (see Pet. 47-48, 52-53).

conditions on the receipt of funds," and not just to "the determination whether a provision is a condition at all" (Pet. 42). This contention is no longer tenable in light of *Bennett* v. *Kentucky Dep't of Education*. There, as here, the dispute involved the interpretation of an existing condition of the grant program (the prohibition against using federal education funds to supplant state funds). The Court made it clear that *Pennhurst*'s "clear statement rule" had no bearing on that question of statutory interpretation (*Kentucky*, slip op. 8 (citation omitted; emphasis in original)):

> The requisite clarity in this case is provided by Title I; States that chose to participate in the program agreed to abide by the requirements of Title I as a condition for receiving funds. There was no ambiguity with respect to this condition, and *Pennhurst* does not suggest that the Federal Government may recover misused *federal* funds only if every improper expenditure has been specifically identified and proscribed in advance.

Thus, the "clear statement rule" prevents only the imposition on the states of "massive" and "largely indeterminate" financial obligations that the states could not have anticipated at the time they agreed to accept federal funding. *Pennhurst*, 451 U.S. at 24. The rule does not apply to the interpretation of arguably ambiguous terms in a statute that the states knew imposed obligations on them. Whether unrecovered excess payments that states make to providers are "overpayments" under the Medicaid statute clearly raises a dispute of the latter type. If the excess payments are "overpayments" within the meaning of the statute, there can be no doubt that peti-

tioner unambiguously agreed to abide by the requirement that the Secretary recoup the overpayments (42 U.S.C. 1396b(d)(2)).[2]

Finally, we note that there is nothing "unfair" about the court of appeals' resolution of this case. As the court noted (Pet. App. 36-37), only the state is in a position to protect itself against the risks of dealing with insolvent providers. Equally significant, a state is not required to employ the "retrospective ratesetting system" used by petitioner. Only 10 other states employ that method; the remainder employ a "prospective reimbursement system," under which providers are reimbursed on the basis of their costs in an earlier year and receive any necessary inflation adjustments later. See Pet. 8-10 & n.6.

b. Petitioner does not address the only issue left in this case after *Bennett* v. *Kentucky Dep't of Education*: whether the Secretary's interpretation of the term "overpayment" is reasonable. In any event, the court of appeals' decision on that issue is correct and does not conflict with any decision of this Court or

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[2] Petitioner cites *Board of Education* v. *Rowley*, 458 U.S. 176, 204 n.26 (1982), as another case in which *Pennhurst*'s "clear statement rule" was invoked (Pet. 45-46, 48 n.23). But that case was much closer to *Pennhurst* than to this case or *Bennett* v. *Kentucky Dep't of Education*. There, the lower courts had read a vague provision contained in the Education of the Handicapped Act, 20 U.S.C. 1412(1), directing participating states to provide handicapped children with a "free appropriate public education," as requiring local school districts to provide not just a useful education but one that would develop the handicapped child's full potential. Acceptance of the lower court decisions would have imposed a massive new obligation on the states, thereby fundamentally altering the character of the grant program and the states' duties under it.

any other court of appeals. Accordingly, it does not warrant review by this Court.

Relying on 42 U.S.C. 1396b(d)(3),[3] petitioner argued below that a state's excess payment to a provider is not an "overpayment" unless the state first collects the excess payment from the provider. But petitioner largely chose to ignore Section 1396b(d)(2), the subsection that deals generally with the subject of overpayments. The first sentence of Subsection (d)(2) requires the Secretary to recover the federal share of any overpayments made by states under the Medicaid program. Subsection (d)(3), on the other hand, authorizes federal recovery of payments that are proper, but that states choose to (but need not) recover from third parties, such as amounts from a recipient's estate. The two subsections thus apply to different situations. The instant case concerns payments under interim rates that were later determined to have been in excess of the amounts allowable under the Act. Congress cannot have intended for the federal government to make payments that turn out to be excessive once a state calculates its final reimbursement rate; indeed, the statute authorizes federal reimbursement only for "medical assistance" rendered under an approved state plan. 42 U.S.C. 1396b(a). Excess payments of the type involved in this litigation do not constitute payments for "medical assistance" within the meaning of the statute. See 42 U.S.C. 1396d(a). Accordingly, the term "overpayment" in Section 1396b(d)(2) necessarily includes the excess payments at issue here.

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[3] The relevant statutory provisions are set forth at Pet. App. 10 n.2.

It is therefore respectfully submitted that the petition for a writ of certiorari should be denied.

REX E. LEE
Solicitor General

MAY 1985

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No. 84-1363

IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1984

THE COMMONWEALTH OF MASSACHUSETTS
by its DEPARTMENT OF PUBLIC WELFARE,
Petitioner,

v.

SECRETARY OF THE UNITED STATES
DEPARTMENT OF HEALTH AND
HUMAN SERVICES, et al.,
Respondents.

On Petition for a Writ of Certiorari
to the United States Court of
Appeals for the First Circuit

SUPPLEMENTAL AND REPLY BRIEF FOR THE PETITIONER

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SUPPLEMENTAL AND REPLY BRIEF FOR THE PETITIONER

Mistaking the issues presented, the Secretary wrongly argues that the petitioner's claims were rejected in a recent decision by this Court. Misconstruing the petitioner's argument, the Secretary

slights its purpose, and concludes incorrectly that her position is consistent with the purpose and policy of the Medicaid Act. The Secretary's argument notwithstanding, the issues presented in this case are now as pressing, and as deserving of review by this Court, as they were at the beginning of the Term.

1. The Commonwealth contests the Secretary's determination that the sum in issue in this case constitutes an overpayment, not her power to recover the sum immediately if her determination is correct. Compare Secretary's Memorandum at 1 with, e.g., Petition at 43-44; Pet. App. at 18-20 (summary of petitioner's argument by the Court of Appeals).

The sum in issue was indisputably expended by the Commonwealth at rates determined in accordance with an approved state plan for purposes stated in the plan, i.e., to purchase medical care for needy persons.[1/] Despite that fact, the Secretary refuses to contribute the federal share of the petitioner's expenditures.

Thus, this case does not involve any dispute as to whether Medicaid funds were expended in violation of grant condi-

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1/ Contrary to the Secretary's Memorandum at 3, the petitioner does not argue that payments to providers become "overpayments" for purposes of § 1396b(d)(2) to the extent that they are recovered from the providers. Rather, the expenditures were proper when made, and so the federal share of them cannot be an overpayment. However, rate decrease claims which are actually recovered from providers may be treated as if they were overpayments because § 1396b(d)(3) so provides. See Pet. App. at 127.

tions, cf. Bennett v. Kentucky Department of Education, 53 L.W. 4333, 105 S.Ct. 1544 (1985), or to purchase services not covered by the Medicaid Act, cf. Connecticut Department of Income Maintenance v. Heckler, No. 83-2136, decided May 20, 1985. Rather, it directly concerns the "cornerstone" of the Medicaid Act, the provision of federal financial assistance "for all legitimate state expenditures under an approved Medicaid plan." See Harris v. McRae, 448 U.S. 297, 308 (1981), citing 42 U.S.C. § 1396b(a)(1).

2. Contrary to the Secretary's Memorandum in Opposition at 5, 7, the petitioner claims both that the Secretary's refusal to contribute the federal share of the Commonwealth's expenditures is a flat violation of federal law, to wit 42

U.S.C. § 1396b(a)(1), see Petition at 30-41, and that the Secretary has exercised whatever authority she may have in a completely arbitrary way, in violation of the spirit of the partnership relationship, and of the "clear statement" rule first articulated in Pennhurst State School & Hospital v. Halderman, 451 U.S. 1, 17 (1978). See Petition at 23-28, 41-53.

Bennett v. Kentucky Department of Education does not foreclose the latter argument. In Bennett, the Court ruled that the clear statement rule was satisfied because there was no ambiguity as to the existence of a condition that grant funds be used to supplement rather than supplant state and local education funds. 53 L.W. at 4335, 105 S.Ct. at

1550. Nevertheless, the Court left open the question whether in a disallowance proceeding the Secretary's power to construe grant conditions could be invoked to impose liability in a way that frustrates the state's reasonable expectations. 53 L.W. at 4336, 105 S. Ct. at 1553. See also Bennett v. New Jersey, 53 L.W. 4337, 4339-40, 105 S. Ct. 1555, 1559-61 (1985) (law in effect when grant is made governs its use).[2/]

Both Pennhurst and Bennett operate against the Secretary's position in this

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2/ In both Bennett v. Kentucky Department of Education and Connecticut Department of Income Maintenance v. Heckler, the Court concluded that the statutes in question clearly supported the federal position. Thus there was no occasion to apply the rule of statutory construction articulated in Pennhurst, or the rule of contract interpretation articulated in Bennett.

case. First, since § 1396b(a)(1) promises "federal financial assistance for all legitimate state expenditures under an approved Medicaid plan," Harris v. McRae, 448 U.S. at 308, the Secretary's refusal to contribute the federal share of petitioner's expenditures, which were concededly made in accordance with its approved plan, amounts to a qualification of, or condition on the federal obligation on the basis of unclear statutory authority.

The Secretary seeks to minimize the implications of her extraordinary claim by noting that "only" ten other states employ a retrospective rate system, suggesting that only those ten will experience the effects of her position. Secretary's Memorandum at 7. However, even if a surprise condition which "only"

affects one-fifth of all the states can slip under the bar of the clear statement rule, the Secretary's position in this case is not limited to states with retrospective rate systems. The Secretary identifies § 1396b(d)(2) as the source of her authority. See Pet. App. 34; Secretary's Memorandum at 4. If that section authorizes the Secretary to withhold federal financial participation here, it equally authorizes her to withhold participation in any state's expenditures under an approved plan, regardless of the type of rate system employed by the state. The only limit on this power recognized in the decision below is that the Secretary must be able to articulate a plausible, even if post hoc, rationale for denying reimbursement. Pet. App. 32-35. Whether this authority is viewed

as a new condition on the states' right to reimbursement, or as a new qualification of the federal obligation, it represents potentially massive, unforeseeable, and indeterminate liability for the states. Since it is not clearly supported by the Act, this power does not exist.

Further, the Secretary's position in this case is the paradigm of the cases on which this Court reserved judgment in Bennett v. Kentucky Department of Education, 53 L.W. at 4335, 105 S. Ct. at 1553. Since the petitioner expended funds in accordance with its approved plan, it seems beyond question that petitioner could reasonably expect the federal government to contribute its share; neither court below found anything in the Secretary's regulations to be to the

contrary. Pet. App. 25-26, 53. Moreover, the Secretary's own regulations encouraged the expectation that the federal government would participate in the petitioner's expenditures. See Petition 7, 15; Pet. App. 26-27 (citing and discussing regulations stating that federal participation is available for expenditures which do not exceed upper limits). Thus, the Secretary's position is in plain conflict with Pennhurst, and also presents squarely the issue reserved in Bennett.

3. Permeating the Secretary's Memorandum is the innuendo that the petitioner is attempting to postpone repayment of misspent funds. That suggestion is unfounded. That the state rate system has identified these funds as overpay-

ments to nursing homes does not mean that they should never have been spent. The Secretary has never alleged that the rates at which the funds in issue were expended exceeded the upper limits identified by 42 U.S.C. § 1396b(i)(1979), or her regulations. Further, the interim rates at which providers are initially reimbursed under a retrospective system are determined in essentially the same way as final rates are determined in a prospective system. See Petition at 8-10. Consequently, if the same expenditures had been made at the same rates under a prospective system, the Secretary would apparently concede her duty to contribute the federal share.[3/] Thus, the Secretary's claim is perversely

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3/ However, if a state employing a prospective system conducts an audit of a nursing home's books after the fact, the Secretary's theory would permit her to

(footnote continued)

based on the fact that, unlike a prospective system, a retrospective system prevents reimbursement in excess of actual, audited costs.

The Secretary argues that her position is reasonable and fiscally prudent. Be that as it may, it is grossly unfair and unlawful for the Secretary to permit the petitioner to expend funds in reliance upon the Secretary's approval of the state plan, and then to refuse to contribute the federal share of those expenditures on a theory nowhere found

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(footnote continued)

determine that any excess reimbursement revealed in the audit constitutes an "overpayment" to the state. In this circumstance, as in Massachusetts's case, the states that are most conscientious about controlling costs are most likely to feel the sting of the Secretary's peculiar theory.

in the statute or regulations. Furthermore, however rational the Secretary's position may be, it implies a relationship between the federal and state governments vastly different from the partnership described by this Court in Harris v. McRae, 448 U.S. at 308-09. While Congress might rationally have enacted the Secretary's view of that relationship, it chose instead to rely on the states' prudent exercise of their discretion, and to share the costs thereby incurred, subject to specific limits which Congress itself established in § 1396b, and subject of course to the Secretary's power to approve or disapprove the plan under which those costs are incurred. There is nothing in this case to show that that reliance was misplaced.

The decision below, upholding the Secretary's refusal to share the petitioner's legitimate expenditures, merits review by this Court because it endorses a dangerous bid by the Secretary for an authority which negates Congress's purpose and the role of states as partners in the Medicaid program.

Respectfully submitted,

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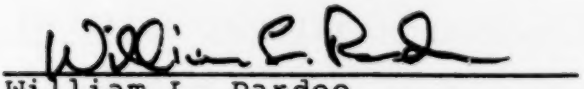

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